



**EALING COMMUNITY SAFETY PARTNERSHIP
DOMESTIC HOMICIDE REVIEW
EXECUTIVE SUMMARY**

**Report into the death of Kat
November 2015**

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Associates Standing Together Against Domestic Violence

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1. Executive Summary

1.1 The Review Process

- 1.1.1 This summary outlines the process undertaken by (Ealing Community Safety Partnership area) domestic homicide review panel in reviewing the homicide of (Kat) who was a resident in their area.
- 1.1.2 The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members: Kat was a British Asian woman of Sikh heritage, although there was no evidence of her practising for some years. She was 48 years old at the time of her death. She was a heterosexual woman from a close family where she was the eldest sister. There is no evidence of any disability and she was not pregnant or a mother. Theo is a Black African-Caribbean man. Theo had some problems with dyslexia which made writing documents difficult. He was 49 at the time of the murder. He was living with his elderly mother for whom he had some caring responsibilities. His daughter (who lived separately) also had care needs following a life changing medical condition
- 1.1.3 Criminal proceedings were completed on 19th May 2016 and Theo was given a life sentence with a minimum term of 14 years.
- 1.1.4 The process began with an initial meeting of the Community Safety Partnership in January when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with (victim/perpetrator) prior to the point of death were contacted and asked to confirm whether they had involvement with them.

1.2 Contributors to the Review

- 1.2.1 This Review has followed the statutory guidance for Domestic Homicide Reviews (2013/2016) issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. A total of seventeen agencies were contacted to check for involvement with the parties concerned with this Review. Three agencies returned a nil contact, five agencies submitted Independent Management Reviews (IMRs) and chronologies, and one agency chronology only due to the brevity of their involvement. The chronologies were combined, and a narrative chronology written by the Overview Report Writer.
- 1.2.2 The following agencies and their contributions to this Review are:

Agency	Contribution (Chronology/IMR/Letter/Other)
The Metropolitan Police Service	Chronology and IMR
The National Probation Service – London Division (formerly London Probation Trust)	Chronology and IMR
Central & Cecil Housing Trust	IMR only
Kat's General Practice	Chronology and IMR

Theo's General Practice	Chronology and IMR
Young Physical Disabilities Team Ealing Adult Services	Summary of Engagement only
London North West Hospitals NHS Trust Integrated Acute and Community Services	Chronology and IMR

1.2.3 Independence and Quality of IMRs: The IMRs were written by authors independent of case management or delivery of the service concerned. Most IMRs received were comprehensive and enabled the panel to analyse the contact with V and/or P, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. Both GP practices were also interviewed by the Chair. The IMRs have informed the recommendations in this report.

1.3 The Review Panel Members

1.3.1 The panel consisted of the following agencies and representatives:

- a. Jessica Donnellan, Chair & Report Author, Standing Together against Domestic Violence
- b. Sally Jackson, Report Author, Standing Together against Domestic Violence
- c. Pam Chisholm – Metropolitan Police Service, Specialist Crime Review Group
(until the 2nd Overview Report Meeting as retired)
- d. Janice Cawley – Metropolitan Police Service, Specialist Crime Review Group
- e. Ben Warriss – Metropolitan Police Service, Ealing Community Safety Unit
- f. Ann Coles – Ealing CCG, Designated Nurse Safeguarding Children
- g. Joyce Parker – London Borough of Ealing, Community Safety Team
- h. Hilary Lucas – Central & Cecil Housing Trust, Area Manager
- i. Stuart Webber - National Probation Service, Head City of London, Hackney and Tower Hamlets
- j. Sophie Shah – London Borough of Ealing, Adult Social Care Services, Service Manager
- k. Pragna Patel – Southall Black Sisters, Director
- l. Caroline Birkett – Victim Support, Head of Victim Support Services for West and South London

1.3.2 *Independence and expertise:* Agency representatives were appropriately independent of the case and were of a suitable level of expertise.

1.3.3 The Review Panel met a total of four times, with the 1st panel meeting on the 6th June 2016 and the final meeting on 5th October 2017.

1.3.4 The Chair and authors of the Review wish to thank everyone who contributed their time, patience and cooperation to this review.

1.4 Chair of the DHR and Author of the Overview Report

- 1.4.1 The Chair and Author of the Review is Jessica Donnellan, Senior Projects Coordinator and DHR Chair at Standing Together against Domestic Violence (STADV). Jessica has received Domestic Homicide Review Chair's training from STADV. She joined STADV in January 2011 to set-up the Domestic Violence: Health & Maternity Project, run in partnership with the NHS. She then developed the coordinated community response to high risk domestic abuse cases through coordinating Multi-Agency Risk Assessment Conferences (MARAC). In her current role as Senior Projects Coordinator she has a diverse portfolio of short and longer term projects including three DHRs. She brings extensive experience of working across a range of statutory and voluntary sector roles including Child Protection, homelessness and independent domestic & sexual violence advocacy
- 1.4.2 Unfortunately, before agreement on the final version of this report, the Chair and Author had to cease her involvement due to a family bereavement. The final version was compiled by Sally Jackson Partnership Manager at Standing Together. Sally Jackson has worked in the violence against women sector for over 20 years in the local, national and international arena. Sally worked as a fully qualified nurse, before moving into the domestic abuse (DA) field, which has included co-ordinating helplines, DA service development and manager of the Hidden Violence team for Portsmouth City Council. In Portsmouth this involved setting up the first health based Independent Domestic Violence Advocate (IDVA) service and one of the first IDVA/Independent Sexual Violence Advocate services. Along with partners she developed the city's Specialist Domestic Abuse Court and Multi Agency Risk Assessment Conference. She managed the city's response to violence against women and hate crime services and supported a very active DV Forum. She has delivered training to professionals from a wide variety of sectors including doctors and international Police Commanders. She is an independent expert advisor on Gender for Office for Democratic Institutions and Human Rights (ODIHR) on Freedom of Assembly. Sally's role at STADV is Partnership Manager which entails ensuring delivery of the operational management of violence against women services across three boroughs (not Ealing) in west London
- 1.4.3 Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides
- 1.4.4 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 50 reviews, including 41% of all London DHRs from 01/01/2013 to 17/05/2016.
- 1.4.5 **Independence Statement:** Jessica Donnellan was the Coordinator of the Multi-Agency Risk Assessment Conference (MARAC) in Ealing from May 2013 to December 2014. STADV also co-ordinate Ealing MARAC. However, as neither Kat nor Theo were known to MARAC, the Safer Ealing Partnership decided that Jessica and STADV had sufficient independence to conduct this review.

1.5 Terms of Reference for the Review

- 1.5.1 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1st December 2010 to the December 2015 which was the date she was found dead. This time frame was agreed as it gave enough time on which to create a picture of their relationship considering that there had been very little contact with agencies. Agencies were asked to summarise any relevant contact they had had with Kat or Theo outside of these dates.
- 1.5.2 *Key Lines of Inquiry:* The Review Panel considered both the “generic issues” as set out in 2013/2016 Guidance and identified and considered the following case specific issues Theo’s behaviour historically, and knowledge of the relationship from both Kats family and workplace. Although not a practicing Sikh, Kats ethnicity may have affected her ability to access local support. Also as a woman she faced the intersecting issues of race and sex
- 1.5.3 As a result Southall Black Sisters were invited to be part of the review due to their expertise in supporting women of colour who are subjected to domestic abuse, even though they had not been previously aware of the individuals involved.

1.6 Summary of Chronology

- 1.6.1 **Metropolitan Police:** Theo had come to the attention of police for perpetrating domestic abuse against three different women on three occasions over a six-year period (between 2000 and 2006). Although none progressed through the criminal justice system. In one of those he was found guilty of dangerous driving and possessing an offensive weapon but not the offenses against his then partner. He was subsequently disqualified and then convicted twice for driving while disqualified. He also used violent and abusive behaviour outside of intimate relationships. There were two incidents in which Theo was present and is both accused of using violent behaviour and alleges being subjected to violent behaviour.
- 1.6.2 **London Probation Trust:** Theo was supervised following driving offences during three discreet episodes, although for inter-related offences, between 2007 and 2009. The offender manager who completed his last pre-sentence report identified: Theo was minimising the seriousness of his actions; Although Theo expressed remorse, his actions were clearly not in line with his stated position and that his remorse seemed to be for having been caught rather than the seriousness of the harm he posed or the failure to comply with Court sanctions; He had ‘inappropriate problem-solving strategies’ and His behaviour was part of an established pattern of offending behaviour, but not anti-social.
- 1.6.3 **General practice for Kat:** During the five-year timeframe under review, Kat had 39 contacts recorded in her GP notes. Research conducted by the Health and Social Care Information Centre¹ found that the average member of the public sees a GP six times a year. Kat was never asked about domestic abuse at the surgery, nor did she volunteer any disclosure. There are two significant and episodic themes in Kat’s medical records: a range of gynaecological issues

¹ Health and Social Care Information Centre, Trends in consultation rates in general practice.

(including contraception, menstruation, urinary tract infection and routine cervical smear screening) which occur during an 18-month period between January 2011 and July 2012; and repeat presentations with unexplained pain (low back, arm, chest and shoulder) which occur over the course of a year from late 2013 until late 2014.

- 1.6.4 **General practice for Theo:** Basic Chronology and accompanying letter was received but no significant indicators that warranted further investigation
- 1.6.5 **London North West Healthcare Trust:** Following symptoms of chest pain in July 2014, Kat's GP referred her for an assessment at **RACPC**. Records indicate that Kat disclosed to staff that she was experiencing 'a lot of pressure at work and at home'. No further details are recorded. However, a letter sent from the cardiology department back to the GP included reference to Kat's 'stress in home life' although it did not specify any further details. **Vascular Department:** Kat had contact with the vascular department between February and June 2015, following a referral relating to a swelling in the left side of her neck. A scan in May returned 'normal' results. **Ear, Nose & Throat (ENT) Department:** Kat had contact with ENT services throughout 2015 which resulted in the fitting of a hearing aid. There is no indication of enquiry or disclosure of domestic abuse during this contact.
- 1.6.6 **Central and Cecil housing Trust:** Theo and Kat resided at his mother's flat: a 2 bedroom general needs tenancy. C&C were not aware that Kat was living there from November 2012. In fact, the designated Housing Officer had never had contact with the tenant, Theo or Kat. Although the flat was shared, Kat and Theo's bedroom was at the end of a long corridor well away from his mother's living accommodation and bedroom affording them privacy. Theo's Mother had no reason to access their bedroom.
- 1.6.7 **Informal Networks – Family:** During the earlier phase of Kat's relationship with Theo, when Kat was living in the family home and keeping the relationship a secret from her parents, her sisters describe thinking of the dynamic as 'fiery'. In November 2012, Kat moved out of the family home and in with Theo. Both Kat's secrecy about the relationship and Theo's race caused considerable upset to her parents. Kat told her sisters, almost immediately after moving in with Theo, that she regretted the decision: she was not as happy as she thought she would be. In summer 2013, Theo's daughter was hospitalised, with a very serious medical condition. This was stressful for the whole family. The demands on Kat increased as she was driving Theo to the hospital every day (he was banned from driving) and, in Theo's consequent absence from the home, took on more responsibility for supporting Theo's mother. In November 2014, Kat told her sisters that things in her relationship with Theo needed to change if she were going to remain with him. She talked about a twelve-month timescale for this to happen. During 2015, Kat's sisters noted the following:
- A swollen lip which Kat said had happened in play fighting with Theo;
 - Burns on her arms which didn't seem consistent with the explanation that they had happened whilst cooking;
 - Using a darker shade of foundation which, in hindsight, may have been used to cover up facial bruising
- In February of that year, Theo lost his job and remained unemployed up to the point of the murder. Two weeks before the murder took place, Kat had told her sisters that she was saving money and looking for a place to rent as she wanted to move out and get away from Theo

1.6.8 Informal Networks – Employer: In 2015, a year before she was murdered, Kat spoke with her employer about several factors she felt were negatively impacting on her: a need for more support with work assignments, the medical condition suffered by Theo's daughter, and 'emotional pressure' from Theo. Her employer responded by giving her some leave from work and providing some additional support to meet the demands of her workload. When Kat returned from the agreed period of leave, she made further disclosures of 'arguments' and 'relationship strains' with Theo, describing one incident in which Theo physically shoved her with such force against a wardrobe that it broke. Colleagues occasionally noted marks, scratches and bruises on Kat's hands and face, but she explained all of these away as 'accidents' although she did confide that she was in the process of saving money so that she could leave Theo and move into accommodation of her own. Following Kat's murder, her line manager advised Police that he had not known how to respond to the disclosures made by Kat about her relationship.

1.7 Conclusions and Key issues arising from the review

- 1.7.1** It is a deeply uncomfortable conclusion that, despite Theo coming to the attention of the criminal justice system on several occasions, and at various levels, this review has found no proportionate changes that could better hold perpetrators like him to account to reduce the likelihood of these known behaviour patterns escalating to murder and protecting the lives of women like Kat.
- 1.7.2** However, it is positive to have identified some ways in which services could better reach those surviving abusive relationships, as we now know Kat did for many years. Until we develop more robust mechanisms through which to hold perpetrators to account for their abusive behaviour, and ultimately prevent domestic abuse from happening in the first place, we will continue to need to develop innovative strategies to educate communities, reach survivors and disrupt perpetrators in order to achieve safety.

1.8 Lessons to be learned

- 1.9 *Serial Perpetrators:*** Some themes emerge for the learning that has taken place throughout this review. The issue of serial perpetrators especially when there is not an index offence of domestic abuse may present a risk but be hard to track, especially if any reported incidents are many years ago.
- 1.10 *Employers:*** Employers have an important role to play in supporting staff who are experiencing abuse, but it is important that they receive training to feel confident and competent to address issues if they arise.
- 1.11 *Wider Community:*** It is important that the wider community knows where to seek help, so that if a friend or family member experience abuse they feel able to offer appropriate support.
- 1.12 *General Practice:*** General practice and especially at routine appointments are an ideal opportunity to enquire about relationships and safety.
- 1.13 *Housing Providers:*** Housing providers also have an excellent opportunity to provide support to tenants who may be experiencing domestic abuse if they have been trained to notice signs and feel confident to talk with tenants safely.

1.14 Recommendations from the review

1.14.1 Ealing Community Safety Partnership

- 1.14.2 **Recommendation 1** Ask both the CRC and NPS to reassure them that offenders without an index offence of domestic abuse but with evidence of domestic abuse in their background are assessed around risk.
- 1.14.3 **Harrow Area General Practice**
- 1.14.4 **Recommendation 2:** Review the current domestic abuse policy to ensure it incorporates learning from this review.
- 1.14.5 **Recommendation 3:** Develop a guideline for triggers for targeted domestic abuse enquiry. abuse (e.g. gynaecological issues, UTIs, unexplained pain) this would be achieved by implementing recommendation 6.
- 1.14.6 **Recommendation 4:** Continue annual domestic abuse training programme, which includes information on use of personal/social information and links to local specialist provision.
- 1.14.7 **Harrow CCG**
- 1.14.8 **Recommendation 5:** Consider the option to commission the IRIS programme.
- 1.14.9 **London North West Hospitals NHS Trust**
- 1.14.10 **Recommendation 6:** Consult with staff across the Trust on the utility and practicability of the domestic abuse policy in its current form and use any information gathered to support the refreshment process.
- 1.14.11 **Recommendation 7:** Domestic abuse training programme to be enhanced.
- 1.14.12 **Recommendation 8:** Supervision around domestic abuse cases to be enhanced.
- 1.14.13 **Central & Cecil Housing Trust (C&C)**
- 1.14.14 **Recommendation 9:** Audit compliance with annual tenancy audit policy.
- 1.14.15 **Recommendation 10:** Expand the tenancy audit policy to include the requirement for Housing Officers to make direct contact with all identified residents as early as possible to identify themselves as sources of information and support.
- 1.14.16 **Recommendation 11:** Develop and implement a stand-alone domestic abuse policy. This policy should include measures to generate greater awareness of domestic abuse amongst tenants and make sources of support visible, including local and national specialist domestic abuse support services.
- 1.14.17 **Recommendation 12:** Create access to domestic abuse training for staff.
- 1.14.18 **Recommendation 13:** Ensure that contracted personnel are appropriately trained to recognise signs of abuse.
- 1.14.19 **Recommendation 14:** Ensure that contracted personnel have and utilise an effective channel through which to alert the landlord to concerns.
- 1.14.20 **Recommendation 15:** Update the Trust's Safeguarding Vulnerable Adults policy to incorporate current legislation and best practice evidence and cross-reference the above with a domestic abuse policy.
- 1.14.21 **Informal Networks:**

- 1.14.22 **Recommendation 16:** Kat's employer to develop and implement a domestic abuse policy and consider joining the Employers Initiative for Domestic Abuse.
- 1.14.23 **Recommendation 17:** Kat's employer to identify and support the development of at least one domestic abuse champion.
- 1.14.24 **Recommendation 18:** City of London/Westminster and Ealing to consider adopting the *Ask Me* scheme.