West Berkshire District Council
Safer Communities Partnership

Domestic Homicide Review relating to the death of Karen in September 2018

Executive Summary

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1. Introduction

1. This Domestic Homicide Review (DHR) examines the circumstances surrounding the murder of Karen in Berkshire in September 2018. The DHR was commissioned by the Community Safety Partnership of West Berkshire District Council.

2. The Overview Report and this Executive Summary uses the pseudonym Karen to denote the victim and Martin to denote the perpetrator in this case. These were chosen to maintain confidentiality and in the absence of agreed pseudonym with the family.

3. Karen was a 28 year old woman who had been in a long term relationship with Martin. She had two children, a 10 year old and an eight year old. Those children were adopted as a result of concerns about their welfare and there was no ongoing contact with them. The perpetrator has two other children from a previous relationship with Karen's sister. He also has another child with another partner.

4. Karen grew up in West Berkshire. Her parents separated and she lived with her mother within a foster family for a period, although there is limited information about this period or the effect it may have had. She had received cautions from the police for offences relating to theft, driving a vehicle without consent and handling stolen goods. She had two convictions; one for criminal damage and another for wilfully insulting a justice.

5. Martin had been in contact with community mental health services locally as well as with mental health services in Nottinghamshire and Wales. He had spent time in prison in Nottinghamshire and was also known to probation services.

6. Martin was a looked after child from the age of 11. He had a lengthy criminal history and by the time of the murder, he had 39 convictions relating to theft, damage to property, resisting arrest, breach of restraining orders, public order offences, assaults and one sexual offence, (sex with a minor).

2. The DHR process

7. A DHR was recommended and commissioned by the Community Safety Partnership in May 2019 in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

8. A first panel meeting was held in May 2019, following a period of scoping and then IMR completion and submission. The process was concluded in April 2020. The DHR panel met three times in person. It also met by teleconference and video as a result of restrictions imposed during the COVID-19 outbreak. The Chair also held discussions by phone with the DHR lead within West Berkshire Council CSP.

Terms of Reference

- Examine the events leading up to the incident including the actions of relevant agencies

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform safeguarding, risk assessment and management

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice

- Review documentation and recording of key information, communication, case management and service delivery of all the agencies involved. Including, but not limited to, access to Police records, legal proceedings' documents and witness statements

- Produce a report that summarises the chronology of events, analyses and comments on the actions taken, and makes any required recommendations

9. In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

- Was the victim known to local domestic abuse services, was the incident a one-off or were there any warning signs. Could more be done to raise awareness of services available to victims of domestic abuse?

- Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?

- Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?

- Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children.

10. Following an initial scooping process, the DHR Panel received and considered Individual Management Reviews (IMRs) from the following agencies:

- A2Dominion
- Berkshire Healthcare NHS Foundation Trust
- National Probation Service
- Nottinghamshire Police
- Nottinghamshire Healthcare NHS Foundation Trust
- Priory Group
- Royal Berkshire Hospital NHS Foundation Trust
- Sovereign Housing Association
- Swanswell
- Thames Valley Police
- West Berkshire Clinical Commissioning Group (primary care)
- West Berkshire Council Children's Services

Panel members

Steve Appleton	Independent Chair and author
Adrian Brunskill	Regional Housing Manager, Sovereign Housing
Beth Sillito	Detective Inspector, Thames Valley Police
Claire Knibbs	Detective Chief Inspector, Thames Valley Police
Tess Snelgar	Detective Constable, Thames Valley Police
Mike Harling	Principal Social Worker, West Berkshire Council Adult Social Care
Elizabeth Porter	Safeguarding Lead, Royal Berkshire Hospital NHS Foundation Trust
Sue Carrington	Domestic Abuse Practitioner, Berkshire Healthcare NHS Foundation Trust
Patricia Pease	Associate Director Safeguarding, Royal Berkshire Hospital
Juliet Penley	Principal Social Worker, West Berkshire Children's Services
Kathy Kelly	Head of Safeguarding Adults, West Berkshire CCG
Melanie Smith	Head of NPS Berkshire, Probation Service
Lorna Skae	Service Manager, A2Dominion Domestic Abuse Service
Nimah Donnelly	Director of Operations, Cranstoun Drug Services/Swanswell[1]
Susan Powell	Building Communities Together Partnership Manager, West Berkshire Council
Jade Wilder	Community Coordinator – Prevention, West Berkshire Council

11. The members of the panel were independent and had no prior contact with the subjects of the DHR or knowledge of the case.

Chair of the review panel

12. The independent Chair of the panel and author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. During that time he worked with victims of domestic abuse as part of his social work practice. He has held operational and strategic development posts in local authorities and the NHS. Before working independently, he was a senior manager for NHS South Central Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

13. Steve is entirely independent and has had no previous involvement with the subjects of the DHR. He has considerable experience in health and social care and has worked with a wide range of NHS organisations, local authorities and

[1] Swanswell is part of the Cranstoun Group

third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

14. Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide and safeguarding of vulnerable adults. He has also led investigations into professional misconduct by staff and has Chaired a Serious Case Review into an infant homicide. He has Chaired and written over 30 DHRs for local authority community safety partnerships across the country. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation.

15. Steve as independent and author has never been employed by any of the agencies concerned with this review and has no personal connection to any of the people involved in the case.

3. Views of the family

16. The panel had wished to ensure that the wishes of the surviving family members have informed the Terms of Reference and are reflected in the report.

17. The Chair of the DHR spoke with Karen's mother, in the company of Karen's sister and their advocate from the charity, Advocacy After Fatal Domestic Abuse (AAFDA). This meeting provided an opportunity to gather further insights and ensure that Karen's mother had the chance to input to the review. Her responses and insights are set out in detail in the Overview Report.

4. Involvement with the perpetrator

18. Contact was sought with the perpetrator via staff at the prison where Martin is currently being held. Contact with Martin was not straightforward. He has experienced ongoing challenges while in prison and did not wish to meet. Indeed the COVID19 outbreak made this impossible. It was agreed that a small number of questions would be sent to him in a letter and that probation and prison staff would support him in responding to these.

19. Martin did make a written response to the questions put to him and that was included in the Overview Report.

5. Conclusions

20. Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided, the panel has reached the following conclusions:

- Karen and Martin had been in a relationship for over ten years. Their relationship was punctuated by domestic abuse perpetrated by Martin throughout their time together.

- Martin has been a serial domestic abuser, who has a lengthy history of convictions and has been a repeat offender. His offences when not directly related to domestic abuse revolved around violence to others, damage to property, burglary, sexual offences, and the misuse of drugs. He has spent a number of periods in prison over the past 13 years or so.

- Martin has experienced mental health problems for much of his adult life. He has spent time as a detained patient in a medium secure forensic mental health hospital. He has been diagnosed with a personality disorder, but there have been changes to his diagnosis, in particular during his time in the secure hospital.

- Karen also lived with the effects of mental health problems, having a diagnosis of personality disorder. She was an occasional user of drugs and had some physical health issues, including epilepsy and hearing loss.

- Karen had experienced domestic abuse over a number of years. She had fled from it, notably to Somerset and then to Oxford. However, her relationship with Martin was one of interdependence and she found it hard to end their relationship. She had attempted to do this on a number of occasions, often when he was in prison or in hospital.

- The wider and longer lasting impact of the removal of her children on Karen does not seem to have been more broadly considered or addressed with her. Whatever the situation at the time, it is known from talking to her mother, that their removal and subsequent adoption was a significant event in her life and one that she found distressing.

- Throughout the DHR the issue of risk assessment, risk grading and risk management have emerged as key themes. The differing approaches of organisations to risk, its assessment and management demonstrate a lack of

consistency and common understanding. It was too reliant on individual practitioners and professionals, on nuances of language and did not take sufficient account of historical factors, concentrating more on the immediate situation in isolation.

- Information sharing between agencies was inconsistent. There are examples of information not being sought, requests for information not being followed up, and a lack of proactivity in both sharing and seeking information about both Karen and Martin. This resulted in agencies not having a full, accurate and up to date knowledge of the history or current circumstances.

- The involvement of organisations with Karen during the period covered by this Domestic Homicide Review was characterised by a lack of collaboration and joint working, with each organisation working in isolation from the others. This contributed to a number of key deficits including:

    - The lack of a holistic view of Karen and Martin's relationship, their interdependence on one another, the risks posed by Martin to Karen, the impact of his wider offending and drug misuse and his mental health problems.

    - A lack of effective communication and information sharing between agencies
    - In some cases a lack of senior oversight of key decisions and actions, and knowledge of these by other agencies
    - Whilst all professional have a role in relation to risk, differing professionals within any multi-agency context will have more contact, time and opportunity to monitor, engage and assess risk.

- The way in which the MARAC was used and operated at the time has been identified within the IMRs as an area for improvement, and some of this work has already been undertaken. However, it can be concluded that those discussions that did take place were not comprehensive enough and were influenced by the variability of view about risk already highlighted.

- Throughout her interactions with agencies, notably the police, Karen downplayed the seriousness of the domestic abuse perpetrated against her. She contextualised and rationalised it. This contrasts with the occasions when she did recognise it for what it was and took active steps to remove herself, both to refuges in Somerset and Oxford.

- It can be concluded that Karen did not always see herself as a victim of domestic abuse, indeed, she may have reached a point in her relationship with Martin where she was almost desensitised to it, it was her normal experience. The agencies that were in contact with her were unable to help her to see differently.

- Those same agencies were unable to work with Martin to address his behaviour effectively.

- This case is one characterised by two individuals with complex needs and interdependencies. The history of domestic abuse against Karen was lengthy and ultimately it ended her life prematurely. The effect of her loss has been profound for her family and those that knew her.

6. DHR Overview Report Recommendations

The DHR panel recommendations are intended to address system wide issues and to support and build upon those recommendations already made and being acted upon in the IMRs.

1. The use of routine enquiry across all statutory bodies in West Berkshire should be monitored. Training should be provided where needed, but ultimately the test of effectiveness is the change in day-to-day practice and this should be subject to regular review.

2. Provision should be made to enable perpetrators of domestic abuse to access support and intervention to recognise and address their abusive behaviour.

3. The changes to MARAC process in West Berkshire should be reviewed to ensure they have been effective and have addressed the deficits highlighted in this and other DHRs.

4. The statutory agencies engaged in this DHR should work together to ensure that current protocols for information sharing between themselves and with commissioned agencies (independent and third sector) are workable, robust and being used routinely.

5. Work should be undertaken to ensure practitioners in the agencies involved in this DHR better understand the nature of protective factors in relationships and are thus well placed to make accurate and sound judgments about those factors.

Agency IMR recommendations

Berkshire Healthcare NHS Foundation Trust

1. If there is a forensic history then attempts should be made to request previous records if available when making assessment in the Common Point of Entry (CPE).
2. A clear pathway to the Forensic Mental Health team should be developed and support accessed to help with assessment. *Since the IMR recommendations were agreed the Head of Safeguarding West of Berkshire CCG, CPE operations manager, clinical director and specialist practitioner domestic abuse met and felt this was not needed as there is a pathway to forensic services*
3. Further Domestic Abuse training provided to CPE in particular to focus on perpetrator risk and mental health and risks to partners when they are being identified as a protective factor. *This action has been completed*
4. Contact made with the Agency who provided the CPE practitioner to feedback performance. *The CPE practitioner has moved to a substantive post in another area.*
5. Entries showing records have been accessed for MARAC should not be concealed and the alleged victim should be recorded on the alleged perpetrator's records and visa versa. *This action has been completed.*

A2Dominion (Domestic Abuse Service)

1. A more systematic and robust approach to follow-up/resettlement contact when residents leave in an unplanned way.
2. Ensuring notifications are sent to the relevant local authority and police force advising of a resident's new location, if known, or recording that this was not possible if not known.
3. Both of the above points could be achieved by conducting a brief case closure review in cases where a resident's move-on is not planned in advance with staff.
4. A2Dominion Domestic Abuse Services will review the "End of Support From" and amend to ensure these practices are incorporated – by 30.09.19.

   Case management could be more robustly demonstrated by:

- Ensuring that responses and outcomes from management decisions are clearly entered in contact logs.
- Ensuring that reasons for decisions accompany such notes.
- A2Dominion Group are developing a holistic case management system which will support a comprehensive case management approach to front line support work; phase two (covering helpline work) is due to go live on 28.10.19, and phase three (covering the remaining ADAS services) will go live at a yet to be confirmed date in 2020.

- In the meantime, the ADAS Service Manager will issue written guidance to the team, and a face-to-face, in-depth exploration of these findings with Team Leaders – by 30.09.19.

West Berkshire Council Children and Families

1. Following a 2nd domestic abuse notification, a referral to be subject to MASH processes. (Agreed procedure 2019).
2. In cases where domestic abuse is a key feature then managers should consider within supervision if there is a need to complete the relevant risk assessment form (DASH) and refer to MARAC
3. EDT to be reminded to check accurately the boundary of Local Authorities and not rely on address names

Swanswell

1. Domestic Abuse information to be made a mandatory field on the assessment form to ensure the question is being asked and the response recorded.
2. All workers to request risk information from Probation when a new order is given.
3. All service users on a Probation order to be offered a 1:1 session once a month as a minimum to complement group work activity.
4. To monitor the implementation of the Engagement Policy, the Team Leader to select a random sample of cases to be discussed at each supervision as well as the cases the worker brings. This will ensure management oversight of cases where attendance is erratic.

The Priory

1. The service in Wales to ensure that a care co-ordinator is allocated to all patients to ensure a robust discharge plan is in place and to co-ordinate between agencies and share information
2. As part of pre-admission risk assessment, the Hospital Social Worker to gather background information on patients social circumstances and share with Multi-Disciplinary Team (MDT) for example forensic history and any active injunctions
3. To ascertain if the patient and former partners are aware of legislation such as the Violence Against Women, Domestic Abuse and Sexual Violence Act 2015 (Wales)

Thames Valley Police

1. TVP to review the process for dealing with intelligence about risk and consider how this is used when determining a domestic abuse level

2. TVP to review its processes for assessing risk in domestic abuse including the role of secondary risk assessing
3. TVP to deliver refresher training about domestic abuse behaviours to all relevant officers and staff
4. TVP to review all aspects of their current MARAC processes, procedures and partnership arrangements. The review will include training, roles and responsibilities, repeat cases referred back to MARAC, and how activities should be recorded in the various systems

Royal Berkshire Hospital NHS Foundation Trust

1. MARAC flags to continue to be placed on the Electronic Patient Record (EPR) for victims of domestic abuse.
2. It is recognised that front line staff are not always confident to discuss domestic abuse with victims and the completion of DASH forms work is on-going to improve this. Updated Trust Domestic abuse policy supports this on-going work.
3. Professional curiosity - continues to be discussed in safeguarding training.
4. Any additional system learning to be integrated

National Probation Service (NPS)

1. To provide information to a forthcoming national review of the work of Central Referral Unit's regarding the difficulties encountered by the worker in making Approved Premises referrals with a view to identifying and implementing process improvements
2. To ensure that the transfer process as set out in PI 07/2014 is fully implemented within Berkshire Local Delivery Unit (LDU)
3. To develop the workers skills in relation to assessment, review and planning
4. To clarify, or formalize, the process for making referrals and reviewing suitability assessments for offenders for accredited programmes provided by the Community Rehabilitation Company (CRC)
5. To clarify the suitability screening & recording process for the Offender Personality Disorder (OPD) pathway project
6. To ensure that the worker is undertaking home visits, recording her monitoring of offender's accommodation and her approval of addresses as required for offender's subject to Post-sentence Supervision (PSS) licence, particularly when this is related to risk of serious harm.
7. For the worker to consider how contact with individuals at risk could contribute to managing risk
8. Pre-sentence Report author to clarify with his line manager the NPS's responsibilities to make courts aware of risk issues when requesting adjournments and deciding on the most appropriate report type. Also, to identify when it is appropriate to consult his line manager in making professional judgements