Safer Lambeth's

Domestic Homicide Review 001

Executive Summary

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Safer Lambeth Partnership

1 INTRODUCTION

1.1 This executive summary outlines the process undertaken by Lambeth's domestic homicide review panel, which examined agency responses and support given to Ms Z a visitor to Lambeth and England, prior to the point of her death on or between 29.12.2012 and 06.01.2013. She was killed by Mr L who she had met during a previous visit to London in the summer of 2012. He pleaded guilty to manslaughter on 18.11.13

1.2 Domestic homicide reviews take place under section 9 of the Domestic Violence, Crime and Victims Act (2004). The statutory guidance[1] states that a domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by -

a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
b) A member of the same household as himself, held with a view to identifying the lessons to be learned from the death.

1.3 Following the death the Safer Lambeth Partnership agreed the criteria for a Domestic Homicide Review were met and a panel was formed to oversee the process.

The Panel consisted of:

Independent Chair & Overview Author
Programme Manager, Community Safety, Lambeth Council
Assistant Director, Community Safety, Lambeth Council
Assistant Chief Probation Officer London Probation Trust
Metropolitan Police, Lambeth Borough Operational Command Unit
Metropolitan Police, Specialist Crime Review Group
Medical Director, South London and Maudsley NHS Foundation Trust

[1] Home Office (2011) *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.* www.homeoffice.gov.uk

Strategic Commissioner, Lambeth Borough of Lambeth and Clinical Commissioning Group
Director of Housing, Lambeth Living (Housing Provider)
Senior Operations Manger, Refuge/Gaia

1.4 The review considers agencies contact/involvement with Ms Z and Mr L from 01.01.2003 to 09.01.2013. Ms Z was a Russian National and was only on holiday in London so there was only a very short period of time the victim was in contact with Mr L (3 weeks). A decision was therefore taken by the DHR Panel to examine in detail services and incidents surrounding 2 previous victims of domestic violence by Mr L and agencies' responses to and services provided to all 4 people, although personal information has not been sought on the previous victims.

1.5 The first meeting of the Panel was held on 31.05.13 to review the information available and decide which agencies should be asked to provide more detailed information.

1.6 Agencies were asked to give chronological accounts of their contact with the victim prior to her death and where there was no involvement or insignificant involvement, agencies advised accordingly. The following agencies were found to have had significant involvement with the perpetrator and one or more of the victims and provided a chronology of their contact and an analysis of that interaction. They considered how far their own policies and procedures had been adhered to and drew conclusions and recommendations in respect of their own organisations.

Metropolitan Police Service: Lambeth
Lambeth Living
Lambeth Housing Options
London Probation Trust
Gaia/Refuge
South London & Maudsley Hospital NHS Trust (SLaM)
Single Homeless Project

The following had some information, which also contributed to the review:

Hampshire Police Service

Essex Police Service

Lambeth Noise Enforcement Team

London Ambulance Service

Guy's & St Thomas' NHS Foundation Trust

Kings College Hospital NHS Foundation Trust

Family Mosaic Service

Care UK (Mental Health providers to HMP Belmarsh)

HMP Hewell

Primary Care (GP)

Information was requested from Job Centre Plus but refused.

Information was requested from 4 other agencies but they told the review that they had no knowledge of the victim or perpetrator.

1.7 Initial consideration of Individual Management Reviews showed that the first victim had been considered by MARAC and the minutes of the relevant meetings were reviewed. The overview author has also had sight of the 2 pre-sentence reports prepared by the Probation Trust on the perpetrator and a Serious Incident Review undertaken by SLaM and a subsequent SLaM Board review.

1.8 A second panel meeting together with the authors of the IMR's supplied was held on to consider the information within the individual management reviews and discuss the overview report were held on: 05.09.13 and 2 further panel meetings to consider the draft overview report were held on: 14.10.13 & 20.11.13.

1.9 The Police report shows they had 2 contacts with Ms Z between 18.12.12 and 28.12.12 both at Mr L's flat. On the first occasion they had been called by neighbours who had heard a disturbance, the couple were seen separately and both were described as "tearful" wanting to spend Christmas together and wished no action to be taken. On the second occasion they were called by Mr L claiming his girlfriend was assaulting him, on arrival all was calm and Mr L said he had argued with his girlfriend about staying out late. On this occasion they were not seen separately and there is not a record of what, if anything Ms Z wanted to

happen. Mr L did leave with the police having agreed to spend the night elsewhere.

2. Key Issues Arising From The Review

2.1. The murdered victim had spent less than 3 weeks in this country with Mr L when he killed her. Although there was some minimum contact with statutory agencies with Ms Z there was little opportunity to have intervened with her in a way that could have protected her. It is extremely unlikely that she knew about or had experienced his potential for extreme violence until the assault that resulted in her death. The only possibility for her to understand the risk she was exposed to, would have been to disclose Mr L's history to her. The Police attended 2 domestic incidents and on both occasions were not fully aware of Mr L's history having been limited in the extent of the checks made which were limited to consideration of the 2 as a "couple". A more extensive check of Police records including by address would have been more revealing. The Metropolitan Police are clear however, that even if the attending Officers at the 2 incidents they were called to had been aware of the extent of his history, there was no legal or policy framework that would have supported disclosure to Ms Z.

2.2. Mr L is a serial perpetrator, however the developing systems of support and protection have understandably focussed on victims. Tracking, responding to and dealing with serial perpetrators is less well developed as a method of protecting victims. This is just starting to change but the circumstances of this review underline the need for it. The learning from this review stems almost entirely from the knowledge of events and interventions in the perpetrator's 2 previous relationships. This is fitting as it contributes to a growing body of knowledge that suggests tracking and management of serial perpetrators has a significant role in protecting future potential victims.

2.3. Mr L suggested to his Offender Manger in August 12 that he might be starting a new relationship. He refused to give any further details. This was technically in breach of his Integrated Domestic Violence Programme (IDAP) order, which

requires the Probation's women's safety officer to contact potential new victims. There was a view from the Probation Trust that the Courts are not receptive to offenders being breached for non-disclosure of details about new relationships and these are consequently not pursued. If this is the case it should be addressed, as this is another way of potentially diverting future victims of serial perpetrators.

2.4. Mr L suffers from an enduring and serious mental illness. There appears to be a strong correlation in his history between relapses in his illness and violence to women. In the last 2^{1}_{2} years his illness and associated risks were not well managed and though at earlier periods of his illness the specific risks to his then girlfriend were identified and noted, this awareness did not appear to transfer when he changed community mental health teams. It was however all available on his client record. There is also evidence that in-patient services were not sensitive to issues relating to domestic violence and saw Mr L's then girlfriend as a useful support mechanism to Mr L, again despite evidence in his case notes and things he said whilst an in-patient that demonstrated his risk to her.

2.5. On the 2 occasions he was placed on Community Orders by the Court for his violence against women, his Offender Managers sought a mental health treatment requirement [2]. This was a potential constructive approach to trying to manage the links between his mental health and violent criminality. However these orders were relatively new and unfamiliar so they did not result in much co-ordinated care planning and management between the Offender Manager and Community Mental Health Team. Nor did they seem to heighten the awareness of the Mental Health Team of the links between the deterioration in his mental health and his risk of causing harm.

2.6. Both of the 2 previous victims were appropriately referred to the Independent Domestic Violence Advocate (IDVA) services in a timely way and followed up.

[2] Criminal Justice Act 2003 Section 207 - “mental health treatment requirement”, in relation to a community order or suspended sentence order, means a requirement that the offender must submit, during a period or periods specified in the order, to treatment by or under the direction of a registered medical practitioner or a registered psychologist (or both, for different periods) with a view to the improvement of the offender’s mental condition.

3. Conclusions and Recommendations

3.1. In relation to Mr L's final victim it is difficult to conclude that her death could have been avoided. Her time in the country and with Mr L was very short and it is extremely unlikely she knew the extent of his domestic violence history or the severity of his mental illness. There were only a very few indications to agencies that Ms Z was present in the flat.

3.2. There appears to be a clear (at least circumstantial) link between Mr L's mental health and his propensity to violence. If Mr L's mental health had been better and more assertively managed in the 2 years before Ms Z's death it is reasonable to assume that the risks he posed when unwell would have been less. Had the South West CMHT acted with urgency and purpose on Mr L's release from prison they may have been able to make a positive impact on his mental health and/or assessed his need for possible compulsory treatment which previous ill health episodes had required. Mr L's mental health needed assertive care management but in the last 2 years at least, he did not receive it.

3.3. If the Police officers who attended on the 18th & 28th Dec had had full information on the extent of Mr L's DV history and some of the mental health concerns, they may have intervened more assertively, however without the power to disclose that knowledge to Ms Z, it is unlikely to have altered the sad course of events.

3.4. **Recommendations**

Individual agency recommendations from IMRs

3.5.***South London& Maudsley NHS Foundation Trust***: - since the death of Ms Z SLaM have undertaken a Serious Incident Review, which formed the basis of their IMR. The Serious Incident Review has been presented to the Trust

Board and its recommendations supersede those contained within their IMR and are included in full below:

Psychosis Community Service (Lambeth South)

The panel acknowledged that the investigation had highlighted serious concerns in relation to the Psychosis Community Service (Lambeth South). The panel heard that there were a number of serious issues, which had a significant effect on the delivery of the service.

The panel acknowledged reports, from service management team, that work was underway within the Psychosis CAG to improve ways of working within the North and South teams. It was however reported that more focus had been placed on the Lambeth North team.

The panel agreed that immediate action was required to improve service delivery in the Lambeth South team and recommend, due to the severity of the issues raised, that the Psychosis Community Service (Lambeth South) be placed on special measures. It was the view of the panel that this should be led by the Deputy Director of Clinical Delivery – Community, in order to:

Benchmark the quality of care and undertake a review of the patient profile (auditing a sample of cases).

Review skill mix & staff training

Review staff competencies

Review management and leadership

Audit risk assessments and care plans

Review caseloads

The panel recognised the impact that placing the team on special measures could have on staff. They therefore concurred with the service management's view that members of the senior management team be present (to provide support) when the amended report is fed back to the team.

Board assurance

This panel considered and discussed the board level processes that were in place, which provided assurance on the monitoring of teams/service delivery. The panel agreed that Board oversight was required to monitor the progress of any service where significant concerns (or patient safety issues) had been raised and/or where assurance was required on improvements to service delivery. It was therefore suggested that one way this could be achieved was via board to ward meetings. The panel were of the view that an additional recommendation should be made, from the Board Level Inquiry panel, to propose that the new Chief Executive review the peer review mechanisms that were in place for such cases.

Impact of organisational change

The panel noted that the investigation report had highlighted that the team had been under a lot of pressure, due to organisational change and increased workloads. The panel were concerned to learn that organisation change had impacted upon service delivery and noted that there had been other incidents, which had also identified organisational change as a contributory factor.

The panel were therefore of the view that mechanisms should be in place to enable areas of concern, which arose as a result of organisational change, to be addressed. As such, the panel propose that, where organisational change is planned, senior staff within CAGs or corporate services should ensure that monitoring systems are in place to mitigate any impact to service delivery and also respond to any issues that arise. The panel were of the view that an additional recommendation should be included to the report to reflect this point.

SI Report Content

The panel wished to commend the investigation team on the structured investigation that was undertaken and also on the quality of final report.

Recommendations

Recommendation 1

'The Trust to commission a piece of work to address interfaces between services within AMH and between AMH and non-AMH CAG services.'
The panel endorsed recommendation one.

Recommendation 2
'All Trust community teams to meet with the SLAM Forensic Service to learn and develop a protocol for management when patients are discharged from prison.'
The panel endorsed recommendation two.

Recommendation 3
'The Psychosis Community Service (Lambeth South) team manager and team consultant to work together to ensure mandatory training in the team is completed and up to date. This will include the following and should be audited to ensure learning is embedded:
-their responsibilities in relation to safeguarding children and adults
-risk assessment and escalation of concerns for complex patient with a history of violence, drug and alcohol use and psychosis.
-Clinical documentation, including ePJs, meeting minutes, correspondence between slam teams and external agencies.'

The panel endorsed recommendation three.

Recommendation 4
'The Psychosis CAG senior manager team to take up the following areas across the CAG in relation to AMH model work. This will include:

Mental health assessments including history, mental state examinations, formulation and resulting care plans

Drug and alcohol and the use of questionnaires available on ePJs, urinary drug screens, hepatitis B & C and HIV status.

Commissioning SLaM partners to work with the Psychosis Community Service (Lambeth South) team to facilitate team members to work together and develop a vision for the service.

Adherence to NICE Guidelines 120: Psychosis with co-existing substance misuse, March 2011. This includes the provision of the Care Programme Approach to deliver care.'

The panel endorsed recommendation four.

The DHR makes the following additional recommendations for SLaM:

DHR Recommendation 1 The Trust audits its clinical staff to establish the understanding of the extent, impact and risk of Domestic Violence and addresses the findings accordingly.

DHR Recommendation 2 The Trust reviews its physical communication systems at Community Team bases and puts in place contingency arrangements in case of failure.

DHR Recommendation 3 The Trust works with the London Probation Trust to develop a working protocol for putting in place and managing Community Order "Mental Health Requirements".

3.6. ***Housing Needs Service:*** The following recommendations appear in their IMR Recommendations for action/improvement: -

All staff to be reminded of the importance of making detailed case notes without abbreviations.

Team managers to ensure monthly case audits evaluate the quality of case notes.

3.7. ***Single Homelessness Project:*** The IMR makes the following recommendations:

-SHP to review the priority and allocations system within the Lambeth Tenancy Support Team
-Review how issues/concerns or incidents concerning client risk are escalated to management level within SHP

3.8. ***The Metropolitan Police Service:*** The IMR makes the following recommendations:

Recommendation 1 Lambeth BOCU

It is recommended that the MPS/Lambeth complete intelligence checks on an address at which a DV incident has taken place in addition to any individual checks undertaken on the individuals involved in the incident**.**

Recommendation 2 Lambeth BOCU

It is recommended that Lambeth BOCU officers are reminded to complete intelligence checks in relation to all Domestic Violence and recorded within the Crime Recording Information System (CRIS). This should include mandatory searches of databases including CRIS, PNC and CRIMINT ensuring that relevant information is recorded within the report.

The DHR makes the following additional recommendation for the Metropolitan Police Service:

DHR Recommendation 4

The Metropolitan Police Service gives consideration as to how, within the existing legal frameworks, relevant Police Officers be given discretionary powers to disclose previous acts of Domestic Violence where potential victims are thought to be at risk.

3.9. ***Essex Police Service:*** **The DHR makes the following recommendation:**

DHR Recommendation 5

A copy of this report to be sent to the Chief Constable of Essex and Her Majesty's Inspectorate of Constabulary drawing attention to the shortcomings identified in the Essex Police responses contained in it, to ensure they are covered by the improvements already made or planned in Essex.

3.10. ***The London Probation Trust:*** The IMR makes the following recommendations:

Recommendation 1 It is recommended that the Assistant Chief Officer for Lambeth should be satisfied that tiering decisions across the borough are soundly based.

Recommendation 2 It is recommended that London Probation and Community Mental Health in Lambeth explore how they might work more closely together to promote the effective management and treatment of offenders with offending related mental health issues. Mr L would be an interesting case example for joint study.

Recommendation 3 It is recommended that London Probation explores whether the role of the WSO could be developed to make them more involved in decision making in the management of orders with an IDAP requirement.

Recommendation 4 It is recommended that London Probation consider how it can refresh practitioners' understanding of the role of MARAC so that maximum use is made of this resource

The DHR makes the following additional recommendation to be read in conjunction with 7.2 recommendation 3 and the internal Probation Trust 2nd bullet point (above):

3.11. DHR Recommendation 6

The London Probation Trust and SLaM work together to develop a working protocol for putting in place and managing Community Order "Mental Health Requirements".

3.12.***Refuge*** The IMR makes the following recommendation:

Recommendation 1 Refuge to record perpetrators' names on REMIT. Refuge has already implemented this change, in December 2012

3.13 ***MARAC*** **The DHR makes the following recommendation:**

DHR Recommendation 7 Consideration is given to reviewing the operating protocol to improve the tracking and management of serial offenders. e.g. Item 10 - Referral Criteria point 3 - Potential Escalation should this refer to number of call outs to a victim and/or an alleged perpetrator?

3.14 **Safer Lambeth Partnership: The DHR makes the following recommendation:**

DHR Recommendation 8

Safer Lambeth Chair to forward a copy of this DHR to the Chair and Chief Executive of South London & the Maudsley NHS Foundation Trust for the information of their Board. The Board to consider any further actions required to augment the internal review already presented to them and any necessary additions to their current action plan.

DHR Recommendation 9 Review the information sharing protocol to ensure it is still relevant, all necessary parties are signed up and understand its operational implications and audit how well it is disseminated across those agencies' staff.

DHR Recommendation 10 The Safer Lambeth Partnership monitors and reviews progress against the Action Plan.

For more information about this document contact:

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