safer haringey

DOMESTIC HOMICIDE OVERVIEW REPORT

EXECUTIVE SUMMARY OF THE REPORT INTO THE DEATH OF ADULT A

Report produced by:
Haringey Domestic Homicide Review Panel

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EXECUTIVE SUMMARY

1. Introduction

This domestic homicide review (DHR) examines the circumstances surrounding the deaths of Adult A and Adult B in Haringey. The Metropolitan Police were called to the home of Adults A and B on the evening of 21 May 2012 after their daughter, Young Person D, was unable to gain access to the home and was unable to contact her parents after returning from school. The police forced entry to the home and found the bodies of Adults A and B. The subsequent investigation determined that Adult B had murdered Adult A and then taken his own life.

2. The review process

This summary outlines the process taken by Haringey's DHR Panel in reviewing the murder of Adult A.

The DHR was recommended and commissioned by Haringey Community Safety Partnership on 14 June 2012 at an initial meeting of all agencies that potentially had contact with Adult A and Adult B prior to the point of death.

Agencies participating in this review are:

- Haringey Community Safety Partnership
- Haringey Council Children and Young People's Service
- Haringey Council Adult and Community Services
- Haringey Safeguarding Adults Service
- Haringey Council Public Health Service
- Haringey Metropolitan Police Community Safety Unit
- Metropolitan Police Critical Incident Advisory Team
- London Probation Trust
- NHS North Central London, Haringey
- North Middlesex University Hospital NHS Trust
- Enfield GP
- Nia, IDVA Service
- Haringey Women's Forum
- Haringey Advisory Group on Alcohol
- School (redacted – sensitive information)
- University (redacted – sensitive information)
- University (redacted – sensitive information)
- Circle 33 Housing Association

Additional information was provided by Tyrer Roxburgh Solicitors, a family friend, church pastor and other professionals supporting the family following the homicide.

Agencies were asked to give chronological accounts of their contact with Adult A and Adult B prior to their deaths. Where there was no involvement or significant involvement, agencies advised accordingly. Each agency's report covers the following:

- A chronology of interaction with the victim and/or their family
- What was done or agreed
- Whether internal procedures were followed
- Conclusions and recommendations from the agency's point of view.

The accounts of involvement with Adult A and Adult B cover different periods of time prior to their death. Some of the accounts have more significance than others. The extent to which key areas have been covered and the format in which they have been presented varies between agencies.

Haringey Children and Young People's Service and Haringey Safeguarding Adults Service have responded as having had no contact with any family members prior to the homicide. Adult A was not known to Haringey's Domestic and Gender Based Violence Services, Hearthstone and Nia.

The Metropolitan Police Service records found no incidents in relation to domestic violence between Adult A and Adult B. Police were called to the family address on one occasion in June 2011; this was not recorded as a domestic violence incident.

The agencies showing contact or interaction with the victim or their family prior to the homicide:

- North Middlesex University Hospital NHS Trust
- Enfield GP
- Metropolitan Police Service
- London Probation Trust
- Haringey Advisory Group on Alcohol
- School (redacted – sensitive information)
- University (redacted – sensitive information)
- University (redacted – sensitive information)
- Tyrer Roxburgh Solicitors
- Circle 33 Housing Association

3. Key issues arising from the review

The risk to Adult A was not clear to, or identified by, any of the professionals and others contributing to this review; the overview report highlights the task facing professionals who are not providing a specialist domestic violence service but who are consulted by those at risk from domestic violence. Recognising this risk and hearing the often hidden or indirectly expressed concerns of those at risk within the busy day to day environment of a public facing service is a significant task. However, many of those at risk may not recognise this risk, or seek help from specialist services, but seek to address the problems created by the abuse they are experiencing through a range of other services. This review recognises the crucial role of staff working in services where the primary role is not responding to domestic violence but who nevertheless have a vital role in providing a route to safety for those at risk.

The task of naming domestic violence and recognising the indicators of abuse, in order to increase the safety of those at risk and to support help-seeking, is the responsibility of all professionals, not only those whose explicit remit is management of risk and safeguarding. While it is not possible to say that a more enhanced response to the possibility that Adult A was at risk from serious domestic violence would have led to a different outcome, the review has made a number of recommendations to improve the ability of professionals to recognise, respond and link with specialist domestic violence services. The aim is to reduce the likelihood that opportunities to intervene will be missed and to improve the early identification

both of those at risk from domestic violence, and those who pose a risk of perpetrating domestic violence.

Adult A had contact with her GP and solicitor in the weeks leading up to the homicide. While she did not present as at imminent risk, a more active response to exploring the possibility that she was at risk could have created opportunities to intervene. Adult B had contact with an alcohol treatment service in 2007 and, while some years before the homicide, the review identified ways in which the ability of the current service to recognise, respond and assess the risk posed by perpetrators of domestic violence could be improved.

Adult B was subject to supervision by the London Probation Trust with a requirement to engage in treatment for his alcohol use. While Adult B's long standing problem with alcohol was known to the Probation Service and to the alcohol treatment agency, Haringey Advisory Group on Alcohol, this was not known by the GP. The correlation between parental alcohol and substance misuse and its impact on the wellbeing of the broader family is well documented. Therefore, where an offender is subject to a community sentence with a requirement to attend substance misuse treatment, this information should be shared between the Probation Service and the GP.

Many of the lessons learned from the review are already being acted upon at a local level and there is considerable evidence of good practice in the development of shared understandings of domestic violence, strategic planning and inter-agency activity.

4. Recommendations from the review

4.1 School

- The school can be commended for having a peer mentoring scheme. This could be strengthened by ensuring that domestic violence and issues around parental separation are covered as part of the peer mentor training. The school should explore effective ways of developing this.
- The visibility of sources of advice and help, and invitations to pupils to access these, should be reviewed. The school may wish to consider using the peer mentors to shape and inform this review.
- The school should review the breadth of its PSHE curriculum to ensure that issues on domestic violence, risk and sources of help are effectively covered.
- The school to participate in the LSCB's link with secondary schools in sharing best practice in relation to safeguarding.

4.2 University A

- University A to explore ways to promote its support services in ways that speak specifically to young men, to consult with agencies with expertise in engaging with men and access appropriate materials.

4.3 University B

- University B to improve consistency across university sites of the information displayed about sources of help for domestic violence.

4.4 North Middlesex University Hospital Trust (NMUHT)

- NMUHT to review its guidance on how the Trust will respond where domestic violence is identified, upon referral or subsequently and specifically where perpetrators and victims of domestic violence will be referred or signposted.

4.5 London Probation Trust (LPT)

- There is no mechanism for an offender's GP to be informed that he or she has received a sentence requiring that they attend a substance or alcohol treatment programme. LPT should establish such a mechanism so that in the future GPs will be informed when their patient is sentenced to attend a treatment programme.
- LPT to be satisfied that there is compliance with enhanced risk management processes and put in place quality assurance processes that ensure practice in line with procedures when in responding to hidden harm..

4.6 Haringey Alcohol Advisory Group (HAGA)

- HAGA to change their records retention policy and bring this in line with other agencies attending the Haringey MARAC.
- HAGA to improve the assessment process in relation to domestic violence. This will require improving the skills and knowledge of staff undertaking these assessments, including skills in exploring abusive behaviour with those who may be perpetrating domestic violence. The approach will need to be both risk and intervention focussed.
- HAGA to improve the level of expertise of staff in responding to domestic violence, specifically skills in responding to domestic violence perpetrators. This will require external expertise and training, particularly in relation to risk assessment and management.
- HAGA to develop a service response to perpetrators of domestic violence that responds to the risk, alcohol issues and use of violence and abuse in relationships.
- HAGA to work with community mental health services to strengthen and clarify referral pathways and joint working arrangements, ensuring these are clear and understood across the service.

4.7 Haringey Drug and Alcohol Action Team (DAAT)

- The DAAT to require commissioned services to have training on identifying domestic violence perpetrators and victims, in line with the Recognise, Respond, Risk Assess and Refer model.
- DAAT to monitor the level of service users of DAAT commissioned services identified as experiencing domestic violence or perpetrating domestic violence to ensure that current screening processes are effective.
- DAAT to ensure that commissioned services are in no doubt as to the need to respond effectively to service users who are using domestic violence by referring to and working with Respect Accredited Services and the LPT.
- All DAAT commissioned services should have a clear contractual direction regarding their file retention policy.

4.8 Circle 33 Housing Association

- Circle 33 to check all records to ensure that no other requests for transfer or support were missed during the period of time where administration systems were weak.
- Circle 33 to ensure that current systems and procedures are able to identify tenants who may be at risk of domestic violence as early as possible.
- All Circle 33 staff to have domestic violence training that is commensurate with their role; this includes administration staff where appropriate.
- Circle 33 to review its current domestic violence and safeguarding policy to ensure it is fit for purpose and in line with best practice in the housing sector.
- Circle 33 to seek out learning from other housing associations on how to improve responses to domestic violence and adopt best practice from elsewhere (e.g. Metropolitan Housing Association and Peabody Trust).

4.9 General Practice

- The General Practice to develop a policy on domestic violence that includes a requirement that all staff have training on domestic violence in line with their responsibilities.
- That information on sources of help for those experiencing domestic violence and for perpetrators of domestic violence is visible and readily available within the Practice.
- The Panel would wish the General Practice to consider adopting the Royal College of General Practitioners' (RCGP) guidance on responding to domestic violence.

4.10 Haringey and Enfield Clinical Commissioning Groups

- The Panel would like clinical commissioning groups (CCGs) to be assured that primary care are adopting the RCGP guidance and considering the IRIS model to improve the early identification of domestic violence.

4.11 Tyrer Roxburgh Solicitors

- Tyrer Roxburgh Solicitors to ensure that all staff working with clients who are at risk from domestic violence, or who may be perpetrating abuse, have training on how to recognise risk, how to respond effectively (including referrals to MARAC) and to have information visibly available in its offices about local domestic violence services and services for perpetrators of abuse.
- Tyrer Roxburgh Solicitors to review whether sending a letter outlining the legal options for removing an ex-partner from the family home should continue as a stand-alone response, or whether this needs to be accompanied by actions that identify and respond to risk.

4.12 Haringey Domestic Violence Operational Group

- The Operational Group to consider the key role of family law solicitors in providing routes to safety for those experiencing domestic violence. The solicitor or paralegal may be the only professional who has any knowledge

that someone may be at risk and they may need support to work safely and appropriately. The borough's specialist domestic violence services work closely with some of the family law solicitors in the area, to the benefit of clients of both services. The partnership between domestic violence services and solicitors is of value and there should be an exploration of providing a kite marking process that acknowledges the enhanced service provided by those solicitors that have staffed trained to recognise and respond to clients at risk from domestic violence.

- The Operational Group to consider a recommendation that Haringey domestic violence services will only recommend legal firms that have achieved the kite mark mentioned above.

4.13 Haringey Domestic Violence Strategic Group

- The Strategic Group should consider the development of an awareness raising programme to assist recognition, response and referral of those at risk from domestic violence to specialist services. This should focus on behaviour and situations of risk which is not limited to physical violence.

4.14 Haringey Children and Young People's Service

- Haringey Children and Young People's Service to find a way to recognise the valuable contribution that can be played by a family friend when they step into a crisis where children are suddenly bereaved. Following the deaths of Adult A and Adult B, a family friend played a very important role in meeting the needs of their children over a sustained period. While there were a number of agencies and professionals looking to the needs of Young People C and D, the needs of the family friend also need to be acknowledged and responded to.