DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

London Borough of Haringey

Case of RB March 2014

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1. Executive Summary

1.1 Introduction

1.1.1 This is the Executive Summary of the Domestic Homicide Review (DHR) into the death of RB. The full Overview Report contains considerable detail about her death and the circumstances surrounding her murder. The intention of this summary is to outline, in a briefer format, how RB came to die in circumstances where her assailant was known to her and the role a variety of agencies played in supporting her and the man convicted of her murder. The lessons to be learnt from this murder are a key element of the Overview Report as well as this summary, albeit described in less detail in the latter.

1.1.2 RB was 42 at the time of her death, a black woman of Jamaican heritage and FL, the perpetrator, was 46 at that time, is Polish and had limited command of English.

1.1.3 The period of the review is considerable (agencies have reviewed their actions back to 2008) and this makes it necessary to deal with some of the information obtained with sensitivity and an acceptance that responses from that earlier period are different to those that have become accepted good practice.

1.1.4 The report has been anonymised and initials are used to identify the victim and the perpetrator. These have no bearing on their real names. Consideration was given to using fictitious names but the panel felt this was not viable due to the family of the victim not wishing to participate in the review process. Additionally, there are two GP practices anonymised as they played key roles in the lives of the victim (RB) and perpetrator (FL) and their true titles would undoubtedly lead to the identification of those individuals.

1.2 The death of RB

1.2.1 In March 2014, RB was stabbed by FL in the street near where she worked as a healthcare assistant (HCA) at the Avenues Primary Care Centre (called such for the purposes of this review) in Haringey. She died en route to hospital. FL was

subsequently charged with her murder and on the 19th December 2014 he was found guilty and sentenced to life imprisonment with a minimum term of 20 years. FL was known to have had an intimate relationship with RB but the exact nature and length of this relationship has proven difficult to define with complete certainty.

1.3 The review process

1.3.1 This DHR is a statutory process which was instigated by the Haringey Community Safety Partnership (CSP). The Terms of Reference are shown at Appendix 1 but its intention is to identify the circumstances in which the perpetrator and victim were known to each other, to agencies involved in their lives and the lessons to be learnt from those interactions.

1.3.2 To ensure those lessons deliver change and improvements in the response to domestic violence an action plan, overseen by the Haringey CSP, also forms part of this process.

1.3.3 The time taken for this review to be completed has been excessive. It was necessary to replace the original independent chair and the approach taken to dealing with a complex case was subsequently revised. The delay cannot be ascribed to the panel members who were consistently supportive.

1.3.4 The panel consisted of every agency that had significant contact with RB or FL and additional information was sought, where necessary, from other agencies. The full details of those agencies is contained within the full report

1.3.5 It was also agreed to recruit a diversity and equality expert to the panel to ensure that we considered those issues and appropriately addressed them within the process.

1.4 The findings of this DHR

1.4.1 There are four main areas for consideration within this review:

i. FL was responsible for RB's death and has been convicted of her murder. For this reason the care, treatment and contact he had with agencies and RB is considered first within this review.

ii. FL was a patient at the Avenues Surgery where RB worked and she treated him over many months. The context of his treatment and the wider role of the surgery are important to learning lessons for the future.

iii. RB was a patient at a surgery in another borough and she disclosed to them that she was a victim of domestic violence and their response is therefore an aspect of the review.

iv. Finally, RB came into contact with a number of other agencies between 2008 and 2011 whose role was either directly or indirectly, to consider her safety and needs in difficult circumstances. This section of the review has been able to identify what could have been done differently but due to the lapse of time this is dealt with more briefly and the panel have agreed to confirm the necessary changes have taken place and this is noted within the report.

1.5 FL and his contact with health agencies[1]

1.5.1 From April 2010 FL was known to health agencies for two principle conditions. He had a chronic physical health problem which required a considerable series of consultations at Avenues Surgery. It was here, where he was largely treated by RB (who was still treating him until 2014) that significant issues surrounding his relationship with RB, the surgery and its practices became evident and are discussed below.

1.5.2 The other medical condition was one of depression which was related to his threats to commit suicide in 2012 when these interventions took place. The Metropolitan Police Service was the first to become involved with FL and his

[1] FL was not known to the police in a significant way.

threats to commit suicide. Their appropriate response was to ensure FL was treated within the NHS. The Whittington Hospital was the initial health agency involved and after in-patient care he came under the treatment of the Haringey Home Treatment Team (HHTT), a service supporting those with mental health issues within the community. Whilst under their care (as an out-patient) he again threatened suicide and was taken to the North Middlesex University Hospital and after a short admission was discharged and the HHTT were informed of this latest episode.

1.5.3 A number of issues arise from these interventions which are addressed in the report and outlined below.

1.5.4 FL was known to be in a relationship with a woman (probably RB) and the safeguarding response to her was inadequate. On one occasion (whilst at North Middlesex University Hospital) it was known that FL had threatened he would kill his girlfriend as well as himself. This did not elicit an appropriate response which should have at the very least involved HHTT being informed of this as they were caring for FL. They were provided with minimal information that FL had been admitted to North Middlesex University Hospital and subsequently discharged.

1.5.5 Clinicians at The Whittington and in the HHTT had assessed the threat FL posed to those with whom he was having a relationship and believed that no real threat existed. This was concluded without the full information which later became available, i.e. the knowledge of FL's threat to his girlfriend possessed by the North Middlesex University Hospital.

1.5.6 Safeguarding policies were found to include a reference to the threat to others known to a mentally unwell individual but it was considered that this was insufficiently prominent and was given insufficient weight. This is especially bearing in mind the heightened risk to others when an individual threatens suicide. It is also possible that agencies focused on the primary, presenting issue and this may have led to secondary concerns being less fully considered.

1.5.7 FL had made it clear that he was in some form of relationship with a member of staff at his GP surgery. This was not considered by those treating FL as an ethical issue and did not lead to further action.

1.6 FL and Avenues Surgery

1.6.1 FL was being treated at Avenues Surgery in the main for a chronic physical condition. Additionally, the surgery knew from letters from the Whittington and North Middlesex University Hospital that he had threatened suicide and was being supported by the HHTT. One letter (Whittington) mentioned problems with a girlfriend and the other (North Middlesex University Hospital) was simply a referral with no mention of any threat to others. The surgery did not respond in any way to these letters apart from noting one “FAO RB”.

1.6.2 Information obtained during the homicide investigation, particularly from the contents of RB’s phone and testimony from the practice manager, demonstrate that FL was stalking RB in 2014, and probably earlier in 2013. The practice manager knew there was, or had been, a relationship with RB of some description, beyond that of a normal patient.

1.6.3 As has been described above FL was treated mainly by RB at the surgery. At FL’s trial and during the preceding homicide investigation it became clear that the practice manager at Avenues was also in an intimate relationship with RB and that he had had contact with FL.

1.6.4 At one point (May and July 2012) FL had been removed from the Avenues practice list with immediate effect because of the fear that FL could threaten RB in some way. He was re-registered within weeks without any form of safeguarding process or review.

1.6.5 The practice manager played a key role in the recruitment and supervision of RB and the processes within the surgery.

1.6.6 The review considered that there were a number of significant areas of concern in relation to the Avenues surgery. These are described below:

- The response to FL and his mental health concerns was inadequate.
- The role of the practice manager is very broad, and in this case there seemed to be a lack of oversight from his employers. His actions were not policy driven and confused by his relationship with RB. His behaviour, as described to the police, was not in keeping with his role as practice manager and with supervisory responsibilities for RB (for example it was known to the practice manager from as early as 2012 that RB's actions went beyond medical treatment for FL and she was involved in non-medical aspects of his life).
- It became clear during the review that the role of the practice manager is defined by those contracted to deliver the service, i.e. the GPs. The role is clearly ill-defined meaning that this review was faced with the problem of holding post-holders to account and allocating responsibility for practice.
- Record keeping was poor and there was no domestic violence policy or effective response to safeguarding needs. For example, the police should have been informed of the concerns about FL when he was removed from the list but they were not contacted. Other concerns were expressed about general systems within the surgery.

1.7 RB and the surgery where she was registered as a patient

1.7.1 In 2008 RB was living with difficulties in her life. She had suffered a bereavement and was diagnosed with depression. She also began to discuss problems she was experiencing with her (then) partner and later disclosed violence within her (then) relationship. In 2013 she appeared to feel she had resolved her issues and no further mention of problems was evident in her notes.

1.7.2 Her GP practice (called Pembrey Medical Centre for the purposes of this review) had evidently supported her well around issues of depression and she was given what was, for the time, relatively standard advice about her domestic concerns, e.g. contact with the police and specialist services. This rather reactive approach

may have been typical then but domestic violence policies and a more proactive approach, as advocated by the NICE guidance[2] would be more appropriate in 2016.

1.8 The response to RB around 2008 and 2011

1.8.1 It was during this period that the police were called by RB to "domestic related incidents". Largely as a result of this, various agencies took a role in supporting RB directly or being involved in her family and domiciliary issues. Much change has taken place since these events and the organisations involved have also changed. For the sake of transparency, the issues of concern are noted below with brevity:

- Police failing to swiftly remove firearms in possession of RB's partner at the time.
- Children's and Young People's Services (CYPS) losing sight of the issue of domestic violence and focussing on other issues (e.g. safeguarding children, not considering the role of alleged perpetrators involved with the family) as well as not communicating effectively with other agencies.
- Specialist support services having poor systems and processes which led to delays and case management issues.
- Housing options not being well-attuned to the needs of victims of domestic violence.
- Family Mosaic (an organisation commissioned at the time to provide floating support services) not providing a female worker, not supervising a poorly performing member of staff well and other communication and system issues.
- Despite the distant nature of the contact RB had with these agencies it was reassuring to note that those agencies participated fully in this review and have

[2] https://www.nice.org.uk/guidance/ph50

addressed all the issues referred to above in a satisfactory way.[3] These issues are more fully referenced within the Overview Report.

1.9 Diversity and help-seeking

1.9.1 It is difficult to establish why RB was not in contact with specialist services when FL was present in her life. Her lack of contact may have been because of her previous experience or her perceptions of the value of the help she would receive. It may also have been because of the fact that she was involved in a relationship with a patient at the surgery where she worked. There may be other complex reasons for not seeking help, but the panel were concerned that her ethnicity, gender or quality of service may have been factors in not approaching supportive agencies and wish that all policies that address the issue of domestic violence consider the issue of help-seeking, especially those from minority ethnic groups.

1.9.2 Specialist services know this to be a concern but are often unable, due to the narrowness of their funding and remit, to provide the breadth of support that would help a woman who is living in similar circumstances to RB.

1.9.3 FL spoke poor English and he should have been offered better support in this regard on a number of occasions to facilitate an understanding of his health conditions and social history, possibly leading to a better understanding of any risk to others.

1.10 Good practice

1.10.1 Despite other problems the Independent Domestic Violence Adviser (IDVA) service at ADVANCE was consistent in its support for RB.

1.10.2 Haringey are also developing, within the parameters of a coordinated community response, a progressive and effective strategy based on a broader violence against women and girls approach.

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[3] This is with the possible exception of the availability of alternative accommodation for victims seeking safety – a wider national concern which this report does not feel able to address.

1.11 Contact with family and friends

1.11.1 It is much to the regret of the new Chair of this Review and the panel that it has not been possible to speak to family or friends of RB. The close family of RB were very clear in their wishes that they not be contacted about this case. It was also not possible to trace friends who could have helped with the process. The practice manger was also unwilling to aid this review. This has led to the challenge of hearing the voice of RB within this review.

1.11.2 Efforts have been underway for many months to contact FL in prison but these, whilst still ongoing, have been unsuccessful and it appears this situation is likely to remain the same.

1.12 Conclusions

1.12.1 The outcome of many DHRs demonstrates that the killing of victims could be prevented. An improved understanding of domestic violence, more effective action (situated with an effective coordinated community response) and the ability to grasp the often limited opportunities that become available to intervene and support are examples of how things must continue to change.

1.12.2 It was not possible to predict RB's death because FL could not have been recognised as being a potential murderer given all previous known information about him. There was also a large gap between his last contact with relevant agencies and RB's death.

1.12.3 Opportunities in this case are noted which could have led to different practical responses which could, in turn, have led to different outcomes, and that may have meant RB not being killed. What it is not possible to establish is a direct link from those practical responses to the murder of RB. Broader approaches to safeguarding, particularly where an individual threatens suicide, alongside better

policies around domestic violence are key issues which require addressing.[4] It is expected that the recommendations within this report will lead to a more effective response to domestic violence. The work in progress within the Violence Against Women and Girls Strategic Group will be a key catalyst in achieving this.

1.12.4 The GP practice needs to develop and improve its management of staff and processes as they relate to the issues discovered during this review.

1.13 Recommendations

Local – for the London Borough of Haringey and related agencies

1.13.1 **Recommendation 4.** That the Haringey Violence Against Women and Girls Strategic Group seeks to enhance its broader response to the issue of domestic abuse and wider VAWG issues – leading to a Violence Against Women and Girls Strategy and partnership VAWG policies.

1.13.2 **Recommendation 5.** Family Mosaic to introduce a policy which includes a system of enquiry of all their clients to assess whether they are experiencing domestic abuse and to take appropriate action following any disclosure of abuse

1.13.3 **Recommendation 6.** That this review is disseminated to the Safeguarding Boards in Haringey for consideration within their local strategies and consideration be given to further dissemination within London or nationally, especially in light of the additional responsibilities for adult safeguarding contained within the Care Act, 2014

1.13.4 **Recommendation 7.** That all agencies involved in this review brief the employees who interacted with RB or FL about the findings of this review (and NHSE to be specifically responsible for informing the Avenues Surgery of the outcome of this review before publication).

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[4] Stalking and harassment, whilst not known to the statutory sector in RB's case clearly played a part in her victimisation and this should be further addressed within the Violence Against Women and Girls Strategic Group.

National Recommendations

1.13.5 The following are recommendations which the panel wish to be instituted on a national basis. The Haringey CSP wishes to kept informed of the outcome of these recommendations.

1.13.6 **National Recommendation 1.** That any individual reporting suicidal thoughts within an NHS environment be routinely questioned about partners or those close to them to assess the risk to those individuals, in the light of the findings of this review and record and respond to that risk appropriately, if necessary informing the police or Multi Agency Risk Assessment Conference (MARAC).

1.13.7 **National Recommendation 2.** That proper recording of all such events within a NHS setting and the risk assessment leads to appropriate information sharing to other agencies that are in contact with either the potential victim or the client. The records must show a decision making process which has considered information sharing and shows the action taken.

1.13.8 **National Recommendation 3.** That all NHS practices institute a domestic violence policy based on good practice and the NICE guidance.

1.13.9 **National Recommendation 4.** That the Department of Health considers defining the specific role of practice manager (with appropriate job descriptions and person specifications) and provide appropriate guidance and support to GP practices that utilise this function to ensure that such guidance is embedded in any contractual arrangements.