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Safer Hull
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Domestic Homicide Review

Peter

Executive Summary

November 2021

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DHR overview report into the death of Peter; November 2019

Preface

The Hull Community Safety Partnership Domestic Homicide Review Panel would like to express its profound condolences and sympathy to Peter's[1] family.

At all times the panel has tried to view what happened through Peter's eyes. We would like to assure them all that in undertaking this review, we are seeking to learn lessons to improve the response of organisations in cases of domestic abuse.

The independent chair and author of the review would also like to express his appreciation for the time, commitment, and valuable contributions of the review panel members and contributing report authors.

[1] Peter is not his true name.

1 Introduction

1.1 This summary report outlines the process undertaken by the Hull Community Safety Partnership Domestic Homicide Review (DHR) panel in reviewing the death of 'Peter' who was resident in their area. 'Peter' and 'Angela' are pseudonym's used in this review.

The main purpose of undertaking a Domestic Homicide Review is to enable lessons to be learnt from homicides where a person dies because of domestic abuse. For these lessons to be learnt, professionals and agencies need to be able to analyse and understand what happened and be able to identify what needs to change and be improved upon to reduce the possibility of further homicides taking place. Peter's death met the criteria for conducting a Domestic Homicide Review under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004.

Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004 and were enacted in 2011.
The Act states:

> (1) In this section "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 learnt from the death.

The term domestic abuse will be used throughout this review where possible, as it reflects the range of behaviour encapsulated within these definitions and avoids the inclination to view domestic abuse in terms of physical assault only.

The term domestic abuse is referenced to the cross-government definition issued under the Home Office Circular: 003/2013, which was implemented on 31st March 2013.

1.2 **Domestic Violence and Abuse definition**

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim

1.3 **The purpose of a DHR is to:**

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

1.4 **Decision to hold a DHR**

1.5 Peter was stabbed in the chest by Angela after an argument over crack cocaine. It is reported that Peter was assaulted by Angela in an argument over the drugs. Peter grabbed Angela by her hair and throat when she ended up on the floor. At that point, Angela, who had knocked a knife block over, grabbed the nearest knife to her and stabbed Peter in the chest.

1.6 On 11th November 2019, the Hull Community Safety Partnership received formal notification and on 18th December 2019, the Community Safety Partnership core panel met to discuss the case and provided feedback to the Community Safety Partnership who then determined that a DHR should be undertaken. The Home Office was duly notified.

2 Overview

2.1 Summary of the incident

2.2 This Domestic Homicide Review Overview Report concerns Peter who was killed during a domestic abuse incident at his home address in Hull.

2.3 Peter lived with his partner, Angela and their two children. Angela pleaded guilty at her court appearance and during the sentencing, the presiding judge Jeremy Richardson described the relationship between Peter and Angela as '*a corrosive relationship that was long term'* and that "*The abuse was perpetrated on you by him and you also perpetrated violence on him on occasion but the greatest violence was on you that caused you to have a deterioration in your mental health*."

2.4 Domestic Homicide Review Panel Members

The DHR panel was comprised of the following:

	Job Title	**Agency**	***IMR**	**Report**
Tony Blockley	Panel Chair	Independent Chair and Author		
Mark Charlton	Head of Community Safety	Community Safety Partnership		
Vicki Paddison	Strategic Domestic Abuse Services Manager	Hull City Council		
Insp Rebecca Dickinson & DCI Emma Heatley	Domestic Abuse Leads	Humberside Police	√	
Kerry Boughen	Named Nurse Safeguarding Children	Humberside Teaching NHS Foundation Trust Adults and also representing the Child and Adolescent Mental Health (CAMHs) Service.	√	
Sarah Hewitson	Hull Customer Service Leader	Department for Work and Pensions	√	
Janice Barnby, Lara Davidson & Gill Sedgwick	Principle Social worker, Group Manager Independent Reviewing Team Manager	Hull City Council Children's Services	√	
Lisa Allan	Vice Principal			√
Chris Davidson & Jayne Wilson	Named Nurse Safeguarding Adults Specialist Nurse	Hull University Teaching Hospitals Trust (HUTHS)	√	

Liz Robinson & Sonia Leake	Interchange Manager Integrated Through the Gate Strategic Manager (HMP Hull & HMP Humber)	The Humberside, Lincolnshire & North Yorkshire CRC	√	
Marianne (Ria) Toutountzi & Maria Quigley	Head of Service (Access and wellbeing) Housing Tenancy Manager	Hull City Council – Neighbourhoods and Housing	√	
Angie England	Vice Principal			√
Tanya Freeman	Associate Vice Principle		√	
Catherine Shadwick & Heather Barnes	Team Manager Group Manager		√	
Dave Blain & Dr Zaro	Safeguarding Adults Lead Named GP	NHS Hull Clinical Commissioning Group on behalf of GP Practices	√	
Debbie Bruce & Jackie Phillips	Safeguarding Practitioner Named Nurse safeguarding	City Health Care Partnership	√	
Vicki Scargill	Senior Probation Officer	National Probation Services Humberside		√
Dawn Clougher	Safeguarding Lead	Strength to Change	√	
Steph Price & Debbie Winning	CEO Service Manager	Independent Specialist DA Service Blue door (Supports male and female victims)		
Martin Belton	Specialist Addictions worker.	Independent Substance Misuse Provider – Renew		
*IMR Independent Management Review				

3 Independence

3.1 Author

Tony Blockley, an Independent Chair and author was appointed by the Hull Community Safety Partnership. He is a specialist independent consultant in the field of homicide investigation and review. With over 30 years of experience in the field and has senior management experience in all aspects of public protection when he was head of crime in a UK police force. He retired from

Derbyshire Constabulary in 2010 and has conducted numerous DHR's was considered appropriately independent.

3.2 All panel members and Individual Management Reports (IMR) authors were independent of any direct contact with the subjects of this DHR, nor were they the immediate line managers of anyone who had direct contact with the persons within this review.

4 Terms of Reference and Scope

4.1 The scope of the review identified critical dates from 1st January 2018 through to the date of Peter's death in November 2019. This date enabled the capture of information relevant to the relationship and agency involvement. Agencies were asked to search their records between those dates for involvement with Peter and/or Angela.

4.2 Specific terms of reference are as follows:

1. Whether the incident in which Peter died was an isolated one or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse.
2. What indicators or signs of domestic abuse did agencies see in relation to Peter or Angela? Whether there are any lessons to be learnt in how previous incidents of domestic abuse were assessed and subsequently managed?
3. Whether there were any barriers experienced by Peter in accessing services.
4. Whether there were any barriers for his family and friends in reporting any abuse in Hull, including whether they knew how to report domestic abuse should they have wanted to?
5. Whether there were opportunities for professionals to 'enquire' as to any domestic abuse experienced by Peter / Angela that were missed.
6. Whether there were opportunities for agency intervention in relation to domestic abuse regarding Peter, Angela or other family members that were missed.

7. The review should identify any training or awareness-raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the area covered by the Hull Community Safety Partnership.
8. The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to Peter e.g., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
9. Whether Peter was 'in need of care' within the auspices of the Care Act 2014.
10. Whether there were any issues in communication, information sharing or service delivery between services or with family members.
11. Whether agencies recognised mental health needs for Peter and/or Angela and how was this identified and managed?
12. Whether the impact of substance misuse for Peter and/or Angela was identified and how did this feature within agency risk assessments and subsequent services that were offered?
13. What was the impact of Adverse Childhood Experience for Peter and/or Angela? (Household dysfunction, abuse and neglect) and how did this materialise within their adult relationship?
14. Whether the impact of domestic abuse within the household was considered from a child's perspective and how did those considerations impact on risk identification, assessments and advice /or services provided?
15. What was the impact of economic issues, how was this considered within assessments and advice/support mechanisms?
16. What was the consideration for Peter and/or Angela in their role of parents towards their children?

4.3 The Review will exclude consideration of how Peter died or who was culpable - that is a matter for the Criminal Courts to determine. It is understood that publication dates may have to change where criminal proceedings are pending, however, these will not prevent the review from progressing.

4.4 The panel met on six occasions, between January 2020 and April 2021. For several reasons, the review has been subject to a series of delays. The trial was delayed on occasions due to the Coronavirus outbreak. The consequences of this were that the IMR reports could not be fully completed, or family members engagement started until after the criminal trial had concluded in August 2020.

The review then sought to engage Angela, Peter's mother and Angela's parents. The independent chair liaised with Children's Services panel representative who spoke to the allocated social worker who agreed to speak to the children so that their voices were heard.

The subsequent impact of Covid-19 presented unprecedented challenges for agencies and the DHR was subsequently placed on hold until agencies could fully invest in the review again.

5 Methodology

5.1 The Review panel determined which agencies were required to complete full Individual Management Reviews (IMR) report, including a chronology (see Section 4) and in what format. They were asked to include information held for Peter, Angela and their children. Some agencies that had substantial information also spoke to staff members to gain a fuller understanding of their involvement and decision making. There were delays for some agencies in submitting their IMR's promptly.

5.2 Agencies were asked to provide a full chronology of contact from the 1st January 2018 through to the date of Peter's death in November 2019. They were also asked to include any relevant information preceding these dates, which many agencies did. This information subsequently informed the terms of reference and lessons learnt.

5.3 Additionally, the panel chair made several requests to other agencies to provide information to inform the review. As a result, 10 agencies completed a short report or provided a chronology. An additional eight agencies were contacted who confirmed that they held no records for either Peter, Angela or their children.

5.4 Each report and IMR report was scrutinised by the Panel and discussed in depth to ensure that any learning could be identified and used. This resulted in further clarification being gained, further information being sought, or additional agencies being identified, and the information requested from them.

5.5 The Panel and IMR authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the terms of reference.

5.6 This report is an anthology of information and facts gathered from:

- Information provided by Angela and maternal grandmother.
- Information provided by the allocated Social Worker for the children
- The factual summary reports provided by agencies
- Agency chronologies
- Individual Management Reviews
- The Police Investigating Officer and investigation reports
- DHR Panel discussions

5.7 All IMR reports and a full merged chronology of agency involvement were distributed to panel members and used to inform discussions and deliberations.

5.8 This information informed the development and finalisation of the Overview Report which was agreed upon by panel members. It was then submitted to the Community Safety Partnership for final ratification before being submitted to the Home Office.

5.9 The recommendations to address lessons learnt are listed in section 8 of this report.

5.10 Hull Community Safety Partnership is responsible for the publication of this report and monitoring the implementation of the action plans.

6 Summary Chronology.

6.1 The review has considered the impact of detailing all the circumstances surrounding the review into a publicly available report and the impact this may have on their children whose wellbeing is paramount. After seeking advice, the Community Safety Partnership do not consider it appropriate to publish all the circumstances surrounding Peter and Angela's relationship and this executive summary will be published. This will not detract from any learning and agencies are committed to ensuring the lessons learnt are fully implemented.

7. Key Findings and conclusions.

7.1 There are a number of findings from the review, particularly focusing on access to services and engagement. Both Peter and Angela were aware of the services available to them and had previously engaged with them. On most occasions, their engagement was limited, and they engaged when it suited them.
Agency-specific findings have been incorporated within the recommendations.

7.2 A key finding is the impact of ACE's on Peter and Angela, and consequently their children.

8. Recommendations

Single Agency Recommendations

8.1 Children's Social Care

8.2 Attendance at domestic abuse training should be mandatory for all social workers dealing with child protection. This would support social workers to make difficult decisions in complex cases and be less likely to make assumptions in a short time period.

8.3 In all cases where a child has indicated harm and the case is open to early help, there should be a visit to see the child and family with a child protection social worker.

8.4 Reflective supervision should become embedded as support for frontline practitioners to support them in making the best possible decision to protect children exposed to abuse.

8.5 **City Health Care Partnership**

8.6 None Identified

8.7 **Hull University Teaching Hospitals**

8.8 None identified

8.9 **The Humberside, Lincolnshire & North Yorkshire Community Rehabilitation Company Ltd**

8.10 Evidence of pro-active re-engagement with service users being undertaken as part of the enforcement process including increased use of Home Visits.

8.11 Evidence that domestic call-out information received following 'known person' checks are consistently recorded on nDelius.

8.12 Supervising officers to have increased awareness around assessing male service users as domestic abuse victims

8.13 **Department for work and Pensions**

8.14 None Identified

8.15 **Hull City Council Housing.**

8.16 Domestic Abuse Routine Enquiry Mandatory training in place for all staff

8.17 For staff to be aware of the indicators and signs of domestic abuse and using visits to properties to be able to highlight any concerns, engaging tenants were appropriate and sharing information with other agencies.

8.18 This links in well with the DA routine enquiry work and also the most recent work around identifying the multiples of repairs taking place at any one dwelling that may indicate DA in the home and starting to have those conversations when it is safe to do so.

Using current technology (Housemark Photobook) - any visits would require an officer response i.e. where there are any signs of damage that could have been caused due to DA would trigger further conversation around how the damage occurred – further routine enquiry

8.19 Looking to progress DA champions across Neighbourhoods and Housing - work just starting on this piece of work

8.20 **School**

8.21 None Identified

8.22 **Humber Teaching NHS Foundation Trust**

8.23 None Identified

8.24 **The Children's Centre**

8.25 Escalation of none/poor engagement by families to identify opportunities to engage in services.

8.26 **Humberside Police**

8.27 In relation to Neighbourhood Policing an increased awareness of the impact of neighbour disputes and making vulnerable adult referrals.

The Neighbourhood Teams work very closely with partner agencies and have good local knowledge of their area's which sometimes can lead an acceptance of behaviour within the Community.

Further training is required in relation understanding vulnerability and safeguarding referrals. This has now been completed by the Force with mandatory training for all Humberside Police staff and Officers.

In order to effectively identify repeat callers and repeat victims to identify any issues, a monthly report is now compiled which is reviewed and tracked via the monthly TTCG (Tasking and coordination group) which is chaired by a Superintendent. This allows support to be put in place and active management to problem solve the issue, those identified will have a Community Beat Manager allocated to them to address any issue, working with partner agencies.

The outcomes of this change will be to ensure community tensions are identified, addressed and resolved whilst supporting the vulnerable.

8.28 Officers must be aware of the risk to children and ensure timely referrals are made, this recommendation is in relation to Child A, not been seen by police after he was assaulted.

All front-line officers have now had further training in relation to the Voice of a Child by officers from the DA units. Outlining the responsibilities and what action needs to be taken. The officers and Supervisors involved in this incident has been spoken to, outlining the failings. The Force will continually refresh the Voice of a Child training.

8.29 Timely referrals to support agencies. The introduction of the DACT ensures that all DA cases are reviewed in a timely manner and the required referrals are made. In this case, this process has failed, owing to Peter being the victim and wanted by the Police, as such there was a time delay in any referrals being made.

A review of the current working practice is required to determine a solution to prevent a delay in referrals under these circumstances.
A recommendation is for the process to be reviewed in these set of circumstances when the victim is avoiding contact with the Police, so we can ensure there are no delays in the referral process.

8.30 **NHS Hull Clinical Commissioning Group on behalf of GP Practice**

8.31 The GP practice will review and update safeguarding policies and procedures with special focus on domestic abuse, substance misuse and to include the following:

8.32 How are safeguarding alerts handled by the GP practice when patients present to the emergency department (ED) with an inconsistent/non-accidental injury, with follow up protocols/processes in place.

8.33 Increased usage of risk assessment tools such as the AUDIT Tool for Alcohol Abuse, with documentation to include consideration of the impact within the household and any linked safeguarding concerns.

8.34 Review and update processes to follow up non-attendance by adults/children at risk.

8.35 Update/ Create Adult at-risk register with a process in place to maintain and monitor patients/families.

8.36 **Strength to Change**

8.37 Recognising ACE's and signposting clients to additional services to ensure their long-term therapeutic needs are met

8.38 To improve engagement through the partner service.

8.39 **Multi-Agency Recommendations**

8.40 From the findings of this review, it is unclear whether ACE's in respect of Peter and Angela's children have been considered this is a key recommendation of this review to consider the support to the two children. This should also be widened to evaluate children in a similar relationship and position.

8.41 Hull Community Safety Partnership should consider the impact of ACE's, working within a multi-agency forum to better understand and develop strategies and practices to ensure identification and support for individuals subjected to such patterns of behaviour.