DHR Executive Summary into the death of Karen

September 2016

Carlisle and Eden Community Safety Partnership

Report author: Lesley Storey

Report completed: September 2018

1. Executive Summary

This summary examines agency responses and support given to Karen, a resident of Cumbria, prior to being killed by her partner, Peter, in September 2016. Karen, a resident in Carlisle, was killed at her home address. Her partner, Peter, was arrested for her murder and is currently serving a prison sentence. At the time of the homicide, the family's two children were in foster care.

The review considers agencies' contact with Karen and Peter from 2009 up to her murder in September 2016. During the period from 2009 up until the arrival of the family in Cumbria in 2015 from Hungary there was very little agency contact apart from police reports. There were no formal disclosures of domestic abuse to any agency. The period from 2015 to July 2016 was characterised by intense agency contact and the review is therefore focused on this period.

2. The Review Process

The review began on 27 October 2016 and concluded in September 2018. The decision. The decision for North Cumbria Community Safety Partnership (CSP) to undertake a Domestic Homicide Review (DHR), was taken by the chair of the Community Safety Partnership on 27 September 2016, and the Home Office were informed on the same day. Following notification to establish a DHR, Cumbria Constabulary and the CPS wrote to Safer Cumbria Partnership and requested that the DHR process was suspended to allow the conclusion of criminal proceedings. The first panel meeting was held in October 2016 chaired by the Chair of the CSP. Agencies were asked to secure records and complete chronologies.

The CSP then appointed an independent chair and report author, Lesley Storey, not directly linked to any of the agencies in contact with the victim, perpetrator or children.

The family were contacted to inform them of the purpose of the review and to ask for their contributions and comments, specifically, were there any issues or questions they wished to explore through the DHR processes. The family did not add any further lines of enquiry to the terms of reference (TOR).

This review followed the statutory guidance for Domestic Homicide Review (2013) issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.During the course of the review the 2016 edition of the Revised Statutory Guidance for Domestic Homicide reviews was released, and this guidance was implemented in both the conduct of the Review panel and the preparation of the Overview Report and Executive.

3. Agencies Involved in the Review

The panel has met a total of five times. The panel, including IMR authors, has not directly line managed any members of staff that had contact with the victim, the perpetrator, or their children.

List of panel members:

Lesley Storey	Independent chair and author
Louise Kelly	Domestic and sexual abuse coordinator – CCC
Clare Stratford	Community safety coordinator – CSP
Sarah Gaskell	Prevent lead – CPFT/NHS
Lisa Handley	Service manager SG HUB – CCC Children's services
Gemma Hannah	Detective Inspector – Cumbria police
Joanne Cunliffe	Unit head (Rasso) – CPS
Jonathon Lear	Sodexo (CLCRC)
Julia Carver	Service lead – Safety Net (UK)
Louise Kitcher	Service manager district – CCC Children's Services
Lee Evans	Operations manager – Victim Support
Lee Sherriff	CSP chair – Carlisle City Council
Louise Gaskell	Coordinator (temp) – CSP
Rebecca Metcalf	Hub manager – HMPS
Louise Mason Lodge	Designated nurse children – CCG North Cumbria
Nicola Byrne	Service manager – LetGo
Simon Parker	Dep designated nurse SG – CCG
Tammie Rhodes	Homeless, prevention and accommodation services manager – Carlisle City Council
Vikki Pattinson	Housing services manager – Riverside Housing

Overview managers who did not attend panel but received minutes:

Anne Cooke	Safeguarding business manager – Cumbria CCG
Melanie Baxendale	Named nurse SG children – NCUH/NHS
Tony Walker	Named nurse SG – NCUHT
Lynn Berryman	Senior service manager – Children's Services CCC
Mark Harris	Head of offender management – HMPS
Donna Cardell	Service manager – The Bridgeway SARC

Also participating in the review were friends and family members.

4. Methodology

On notification of the domestic homicide, all relevant local agencies were contacted. Agencies were asked to secure their files if contact was confirmed. A scoping meeting was held on 1 November 2016, chaired by Lesley Storey. As a result of this meeting, the following agencies were identified as possibly having information on the family: North Cumbria University Hospitals Trust (NCUHT); Clinical Commissioning Group (CCG); Ambulance Service; Carlisle City Council; Children's Social Care and Education Directorate; Victim Support; Cumbria Constabulary; LetGo; Riverside; Cumbria and Lancashire Community Rehabilitation Company; The Crown Prosecution Service.

All agencies who had contact with individual family members have submitted a chronology. Those agencies with direct contact have also supplied an Individual Management Review (IMR). A total of 13 agencies were initially contacted to check for any involvement with the parties concerned with this review. One agency returned a NIL contact - this was the Ambulance Service. Eight agencies submitted an IMR.

The panel is grateful to the Crown Prosecution Service who provided an IMR and advice to the panel on matters relating to the investigation of serious sexual assaults.

In addition, this review draws upon the report written in August 2017, entitled: Operation Zaatar, by the Independent Police Complaints Commission.

The panel were able to interview friends and neighbours as part of the review and received a letter from Karen's mother.

Previous Domestic Homicide Reviews were also examined. This ensured lessons identified in those reviews had been implemented, and learning disseminated across the partnership. This area has had 3 previous DHRs.

The following agencies and their contributions to this review are:

Carlisle Constabulary - **IMR provided**

North Cumbria University Hospitals Trust (NCUHT) - **IMR provided**

Clinical Commissioning Group (CCG) - **IMR provided**

Carlisle City Council - **IMR provided**

Children's Social Care and Education Directorate - **IMR provided**

Victim Support.

LetGo - **IMR provided**

Cumbria and Lancashire Community Rehabilitation Company - **IMR provided**

The Crown Prosecution Service - **IMR provided**

Riverside - **IMR provided**

Independence and quality of IMRs: The IMRs submitted by LetGo , Carlisle City Council, North Cumbria University Hospitals Trust (NCUHT), Clinical Commissioning Group (CCG) Cumbria and Lancashire Community Rehabilitation Company and The Crown prosecution Service were comprehensive and addressed the terms of reference.

The IMR provided by Cumbria Constabulary, Children's Social Care and Education Directorate, Riverside and Victim Support required revision and contributed significantly to the delay in timescales.

5. Summary of Chronology

Karen and Peter met in Hungary their country of origin, the exact year is unknown. Karen's family had concerns from the onset about Peter and sadly Karen became distanced from her family as her relationship with Peter grew stronger.

Sometime in 2009 the couple came to the UK, they rented a flat in London and both the children were born in the London area. Little is known about the family during this time, contact with services were related to the pregnancy and birth of the children.

In 2015 the family moved to homeless accommodation in Cumbria and concerns were raised regarding the care of the children within the first days of residency within the homeless unit. The children were noted to be poorly dressed for the weather conditions and lacked toys, milk and other basic items. A support package was put in place that included essential items to help the family.

A referral was then made into the Safeguarding Hub as concerns escalated quickly due to the constant requests for further support for essential items and concern the family had not registered the children with GP.

On 21 October a health visitor noticed a bruise on Child B and this escalated the child concerns into the child protection arena. A Section 47 investigation was initiated, this included referral to Cumbria Constabulary and a medical assessment for Child B was discharged from the hospital into the parents' care and assessments continued in the early help arena.

In early November the family signed up for a new tenancy and Karen was now employed in a local factory, Peter was the full-time carer for the children while Karen worked.

Concerns regarding the children continued and on 30 November a child and family assessment meeting was held, and Peter and Karen were informed as little progress had been made regarding the care of the children the Local Authority would be seeking legal advice and intended to apply for an interim care order in respect of both children. This was granted in December 2015 and both children were placed in foster care.

In July 2016 Karen reported to CC that Peter had assaulted her. He had smashed the baby's cot and had beaten her with a wooden stick from the cot and then tried to push her down the stairs. Peter was arrested, charged and remanded in custody. This was the first occasion on which Karen informed any agency she was involved with that domestic abuse was occurring. The panel noted the unusual nature of her

disclosure as we know typically a victim of abuse will turn to informal support initially then usually a health professional or other agency before reporting to the police.

Karen then took a further step and on the following day at family court she requested she was assessed as the sole carer for her children. Peter was thought to be "sleeping rough" at this point and Karen was living alone.

On 26 July CC conducted a routine safety check on Karen and Peter was found at the house, he was arrested and again put before the court. He was sentenced to 100 days imprisonment.

Karen was referred into Victim Support and LetGo who provided the IDVA Service, her risk level was assessed initially as standard by CC then raised to high by LetGo. Despite being recognised as high risk Karen was not referred into the MARAC process, this was explored in significant detail through the DHR process.

Karen engaged fully with the IDVA from LetGo and through the support she received began to have the confidence to tell her story. Karen was assisted by the DASH risk assessment to speak out about the sexual abuse she had experienced, she disclosed multiple rapes and assaults and said, "I have never told anyone before now". Karen was adamant she did not want to report this to CC. Karen also reported Peter had threatened to kill her and she was very afraid, she also disclosed Peter had physically assaulted Child B.

Karen continued to work with the IDVA and a safety plan was implemented and developed. Her neighbours informed us that during this time Karen flourished, she felt hopeful she would have her children returned to her care. She was able to buy clothes, have her hair styled, she felt she had a future.

CC made contact with Karen firstly through the IDVA then directly to Karen. Karen was interviewed regarding her rape and the physical assault on Child B, she gave an account of multiple rapes and how she had tried to say no. Karen remained adamant she did not want to support a prosecution, she at no point gave any indication she had changed her mind. Despite her request that no action was taken regarding the rapes. On 13 September on release from prison Peter was arrested and interviewed regarding the rape on Karen and physical assault on Child B.

Peter denied all allegations made against him, he blamed Karen saying she wanted to take his children from him and move back to Hungary. He also said Karen had depression and had been abused as a child. CC took the decision that as Peter had denied all the allegations and no further lines of enquiry were established the investigation did not meet the threshold for referral into the CPS and the case was No Further Actioned (NFA).

Peter was released from police custody, Karen was called but she did not answer so a message was left for her advising her of the NFA.

On 14 September the IDVA called Karen to offer support and to ensure Karen knew of the outcome of the rape investigation. Karen confirmed she did and said she was very stressed and wanted to leave her job. She also said she was going to get a letter to prevent Peter from coming to their house. The IDVA rang CC to request Karen was contacted as soon as possible.

Later that day an officer from CC did attend Karen's house to complete a welfare check and to explain Peter's licence conditions.

On 15 September Karen was killed by Peter, he broke into her home and attacked her with a rock. Her neighbours heard screaming and called 999. Karen was found to have injuries incompatible with life.

6. Conclusions and Recommendations

This review considered whether there are ways of working effectively that could be passed on to other organisations or individuals. In particular, we have considered what lessons are to be learned that may benefit other women in Karen's situation.

This review found several services needed to do further work to establish safer and more victim-focused ways of working. Underpinning these findings was a fundamental lack of understanding of both the nature of coercive control, and its impact on a victim's life. It was also found services did not fully appreciate the nature of financial abuse and how this can both manifest and impact on a victim's life.

Further work is needed to ensure victims of rape and sexual abuse receive the support they need, and that no victim of any sexual offence is taken beyond the remit of their wishes in relation to prosecution of the offence. The principle of prioritising safeguarding, before securing a prosecution, should be considered.

The panel were concerned that the provision of ISVA services was limited to a series of telephone calls, and the victim at no point received face-to-face contact or support. Clear timescales for contacting victims, based on risk and need, should be in place for all victims of rape and sexual assault.

Clearer referral pathways need to be in place for victims of rape and sexual assault to ensure they are given the highest possible standard of service, as early as possible.

The review uncovered a lack of professional curiosity in service areas, notably children's social care and health services. Children's social care undertook multiple assessments on the family, yet at no time, including in preparation to accommodate the children, did any member of staff ask questions in relation to domestic abuse. There was evidence that a "Think Family" approach was not present, reliance was instead placed on Karen and Peter to self-refer and find services for themselves.

Critically, despite the interventions of many different professionals in the family's life, the extent of the domestic and sexual abuse did not become visible until specialist services became involved. This highlights the importance of ensuring families get specialist support as early as possible.

There were also significant gaps uncovered in the implementation of existing policies and procedures; the starkest example of this is the MARAC procedure. It was simply not utilised, with key individuals either not making referrals due to error, or overriding the process based on their individual viewpoint that the process was not required. Safeguards were not robust within the system to adjust for human error. As a result, no multi-agency safeguarding, or information sharing took place. If Karen had been referred into the MARAC, issues such as her housing situation and the impact of the arrears, could have been discussed. The MARAC could have provided a more

coordinated response. The panel noted that in a relatively short period of time multiple contacts were made with the family from multiple agencies. This may have been deeply confusing for both Karen and Peter, and the MARAC could have provided the coordination of services needed.

The review also uncovered recording of actions and record keeping as an area for improvement. CC have identified on a number of occasions there was confusion as to which officer had taken which actions. This caused considerable issue for the DHR panel, and we are aware some specifics were never fully uncovered.

Poverty, economic abuse, and the linkages to the neglect of the children were themes noted throughout the review. Karen's neighbours stated they had never seen poverty at this level before. Karen was in receipt of "poverty wages" on a zero-hours contract. She had little control of what her money was spent on and was denied access to basic resources, such as food, clothing, heating and lighting, and so, by proxy, were her children. The panel were in no doubt that the presentation of neglect was underpinned by coercive control and economic abuse. The panel therefore welcomes focus on the concept of "economic abuse" as an aspect of "coercive control", which government has recently highlighted.

This review presented a challenge to the panel, in that Karen, due to her long working hours, was difficult to reach. Her employment was a significant barrier and the panel debated at length how those barriers could have been overcome. The panel's view was that the Cumbria Domestic Abuse Champions' network was well placed to begin identifying champions in the private sector. Targeting the largest employers, specifically those who have large numbers of female employees on zero-hours contracts, was seen as a step towards overcoming this barrier.

This review uncovered the difficulties police forces have in accessing information that is vital to managing the risk posed from foreign nationals. Further work is needed at a national level to enable police forces to have the information they need to manage risk and safeguard victims.

Robust referral pathways need to be developed and implemented to ensure adults with needs in their own right are referred directly into services rather than signposted. Both adults in this review had mental health needs, which they clearly articulated on a number of occasions, yet no referral was made by agencies into adult safeguarding.

A critical issue uncovered through the lens of this DHR, was the lack of support and supervision post-release from prison for Peter. A robust post-release plan could and should have been implemented to ensure Peter had suitable housing. Peter was released from prison and the only home he had was the home he had shared with Karen. He gravitated back to this home after a short period of time sleeping rough. This dramatically increased the risks to Karen, and both CC and CLCRC were aware of this, yet neither agency made a referral or shared this information with Carlisle homeless section, who could have assisted.

7. Good Practice

Front-line police officers were found to have a proactive approach to domestic abuse and the review panel commends this. Action was taken by officers that ensured Peter was put before the courts, and again, when he breached his bail conditions, measures were taken to ensure he was arrested and imprisoned. This undoubtedly gave Karen the space and confidence to speak out about what she had been enduring for many years.

LetGo provided support and advocacy to Karen and professionally challenged CC on their decision not to put the case into MARAC. They are to be commended on the delivery of care they provided. LetGo are a leading-light project and, as would be expected of a service of this level, were open, transparent and self-critical in embracing the principles of a DHR.

Health visitors were noted by the panel to have gone over and above the duty of care they are bound to provide. Toys, food, clothes and other essential items were provided on multiple occasions. The health visitor was persistent in her approach, and we know from Karen's neighbours that the kindness demonstrated was greatly appreciated.

Carlisle City Council's homeless unit provided a high standard of care and were proactive in identifying early on that the children were subject to neglect. Appropriate services were also put in place to ensure income maximisation.

8. Lessons Learnt

IMR authors identified the following learning points:

Recommendations from LetGo

To establish a course of action that will be taken following disclosures of historic abuse so victims can receive the information they need to make decisions.

Recommendations from Crown Prosecution Service

A reminder should be given to CPS North West prosecutors about the use of ancillary orders and toolkits, to ensure consideration is given to appropriate applications for restraining orders and other appropriate orders, and that such considerations are appropriately recorded.

Rape toolkits should be used in all appropriate cases to assist in identifying evidential issues and further areas of investigation.

Early investigative advice (EIA) should be considered in all appropriate cases, in accordance with the Director of Public Prosecutions Charging Guidance, fifth edition.

Further training to raise the awareness of police supervisors in relation to consent toolkits; EIA may be of assistance, together with an evaluation of such training.

Recommendations from CCG IMR

Primary Care should ensure that information relevant to the immediate family is recorded in records for each individual within that family and cross-referenced to other members. This will allow the identification of any safeguarding issues, and thus prompt a consideration of the need for a discussion with other health colleagues or with other relevant agencies. Assurance that if this is the case it will be provided through completion of section 11 audits, by practices and safeguarding assurance visits by NHS North Cumbria CCG.

Safeguarding concerns, including domestic abuse, should be considered and recorded at key contacts with primary care. In particular these would include any referrals for maternity, any episodes of mental health or emotional well-being concerns, and consideration of issues relating to the children in the family for failure to thrive, non-attendance at appointments, and injuries. The author would recommend that this is included in a wider, multi-agency audit, reviewing domestic abuse across the locality.

Recommendation from Cumbria Constabulary

Community Safety officers to attend MARAC.

Community Safety officers to be made aware of all high-risk victims.

An additional MARAC date should be considered if all MARAC referrals cannot be heard on the day.

Criteria should be made for enhanced, foreign national conviction checks.

Recommendations from CLCRC

CLCRC developed a robust action plan to implement lessons identified through this review. This included:

Practice development unit (PDU) to develop and deliver a development session to responsible officers, to improve the quality of risk assessment sections within OASys.

The PDU to undertake dip sampling of responsible officers' OASys assessments.

PDU to undertake development sessions with responsible officers to re-emphasise the importance of raising risk of harm concerns in the Through the Gate process, with the prison resettlement team.

PDU to include, in discussion with responsible officers, the importance of fully investigating potential risks of harm to children.

It should be noted that all of these actions have now taken place, without exception.

Recommendations from Cumbria Partnership NHS Trust

To review and develop initial assessment documentation throughout CPFT to incorporate routine enquiry questions regarding domestic abuse. This should include all patients (aged 16 plus), regardless of gender, sexual orientation or cultural background. A further prompt for staff to consider any cultural differences may be added after further consultation has taken place.

To promote staff attendance at LSCB training whilst in-house training is being developed.

Lessons identified, and implemented, by the trust, were to update the domestic abuse policy to include flow charts to support staff when domestic abuse is either suspected or disclosed, and to promote information relating to domestic abuse through the existing Domestic Abuse Champions' network, so team leads can cascade this throughout teams.

9. Multi-Agency Recommendations

Strategic and operational:

Training that reinforces "front-line" risk identification, and risk management strategies for domestic violence and abuse, including **coercive control and the links between domestic abuse and sexual violence,** across all agencies. This training should encourage routine enquiry in practitioners and managers undertaking assessments, and those managing responses.

Review the MARAC **protocol** within multi-agency context.

Explore ways of enhancing GP responses to domestic abuse and coercive control that enhance outcomes for victims, perpetrators and children. This should emphasise the importance of GP representation with the MARAC process.

Explore methods of reaching out to employers – developing workplace domestic abuse policies through the existing champions' network.

Establish clear victim-focused referral pathways for victims of rape and sexual assault. **Consider integrating IDVA/ISVA services** so victims receive a joined up, cohesive offer from a single point of referral.

Implement the Domestic Abuse Housing Alliance (DAHA) scheme to ensure victims of domestic abuse, at whatever risk level, get the support they need.

Refresh local community engagement strategies; aim to build confidence in communities of statutory responses to violence and abuse, and ensure those statutory responses are increasing the opportunities for marginalised groups to feel, and be safer, because of those interventions.