Bristol Community Safety Partnership

Domestic Homicide Review

Executive Summary of the Overview Report

8th January 2018

Victim, Adult Female, Maggie Johnson (pseudonym)

Author, and Independent DHR Chair,
Ian Kennedy BA (Hons)

1. Introduction

This Domestic Homicide Review examines the circumstances surrounding the death of Maggie (pseudonym) a woman in her 40's, in Bristol.

1.1. On the afternoon of Maggie's death in August 2016, police were contacted by a relative of her partner, Jim Trainor (pseudonym), after he came to her house to say he had just found Maggie dead in the tent in which they had been living together for several weeks in Bristol. She had previously lived in Bournemouth for most of her life with a number of partners.

1.2. On the afternoon of her death, Jim told police he had been with Maggie at the tent when she sent him to obtain some illicit drugs for their use. He had returned instead with alcohol. Angered by this, Maggie sent him away again to buy drugs, threatening to kill herself with a craft knife if he would not. She had held it to her own throat. When Jim returned some time later he found Maggie lifeless in a pool of blood in the tent. She had a number of wounds to the side of her neck. Paramedics attended but were unable to save her life.

1.3. A subsequent post mortem identified that the wounds to Maggie's neck, one of which had cut her jugular vein, were self-inflicted. Following a police investigation by Avon and Somerset police a Coroner's Inquest concluded that she killed herself. She was known to agencies in Bournemouth as a result of her chaotic lifestyle and risks deriving from sex work, drug and alcohol use, self-neglect, risk of overdose and domestic abuse from Jim Trainor and previous partners.

2. The Review Process

This summary outlines the review undertaken on behalf of Bristol Community Safety Partnership (CSP) into Maggie's death. She did not die as a result of homicide, she died as a result of her own actions. However, her death does fall within the broader parameters for the requirement for a Domestic Homicide Review (DHR), given she killed herself and also had a history of being the subject of domestic abuse and recipient of agency intervention. This is as set out in the Multi-Agency Statutory

Guidance for the Conduct of Domestic Homicide Reviews (December 2016). It is unfortunate that the title 'Domestic Homicide Review' does not accurately reflect enquiries in to suicide and can mislead.

2.1. The decision to hold a review was made at a meeting of the Bristol CSP on the 30th September 2016, and the Home Office were informed. The Independent Chair and report author, Ian Kennedy, was appointed to lead the review.

2.2. Maggie Johnson had had a challenging life by any standards. She had been brought up by her maternal grandmother, after being adopted by her at an early age. Her mother, who was very young when Maggie was born, had been brought up as her sister.

2.3. She had three children who were adopted when they were very young (in 1995 (aged 3-4years), 2003 and 2008 (both at birth)) and it is not thought she had any further contact with them, apart from some contact with the oldest child who sought her out when he turned 18. The third child had been removed for reasons including domestic abuse.

2.4. She was not believed to have had any contact with her natural family for many years. Consequently, the Independent Chair decided that it was not productive to contact her family for assistance with the DHR as it may actually have been unnecessarily intrusive, especially for the children, who could have nothing to add or may not even have been aware of their mother.

2.5. The agencies participating in the review were-

- Avon and Somerset Police
- Avon and Wiltshire Partnership Mental Health NHS Trust
- Bournemouth Borough Council- Adult Social Care Teams: Social Work Bournemouth Assessment Team(SWBAT) now Drug and Alcohol Statutory Services Team, Statutory Services Team, Policy and Service Development Team
- Bournemouth Borough Council Community Safety Partnership
- Bournemouth Borough Council Strategic Housing Options

- BCHA
- Bournemouth Drug and Alcohol Commissioning Team (DACT)
- Bournemouth and Poole Rough Sleeper Team (invited to take part but declined due to lack of contact by their agency)
- Dorset Police
- Dorset Healthcare University Foundation Trust
- NHS Dorset CCG on behalf of GP Services
- South Western Ambulance Service

2.6. Lead professionals from each agency met on a number of occasions at meetings Chaired by Ian Kennedy and work continued between meetings, communicated by secure e-mail to complete the work in a timely and appropriate manner. Each agency that had had dealings with Maggie completed Independent Management Reviews (IMR's), covering the period from 2010 when her relationship with Jim Trainor is believed to have commenced. It was also left open to agencies to look further back beyond that period for any information that may be of relevance.

2.7. The purpose of Domestic Homicide Reviews is as set out in the Home Office document but in simple terms is to carry out effective reviews, to identify learning and suggest improvements within and between agencies to prevent future domestic abuse deaths and improve safeguarding for service users.

3. Findings of the IMR's

Looking across all the separate reviews and the records of each agency it is reasonable to say that Maggie approached, and worked with, agencies when she saw personal benefit, including for example-

- attending the GP's of her own volition, after a sequence of failed appointments, to ask for a letter to help with a housing application or further drugs.
- engaging with her drug treatment provider when she wanted to try a period of detoxification.

- reporting the assault with the mop handle to police to get her partner arrested to ‘teach him a lesson’ and then almost immediately withdrawing support for a prosecution.

3.1. Her situation was driven by choices she had made in earlier life and then driven by her drugs and alcohol misuse. We will never know if she intended to take her life when she cut herself to the throat to make her partner go and fetch her drugs. She had mental capacity and had never talked of suicide. It is reasonable to say that she could often be challenging and disruptive towards professionals and their efforts to help her. Despite this, the review showed some great dedication and commitment to help Maggie among the various agencies, particularly by her social worker, her GP, and the staff at St Pauls where she spent periods living, in the supported short term accommodation they provide for homeless people.

3.2. Had she died from her fragile health aggravated by her living conditions and substance misuse, as opposed to at her own hand, it would not have surprised some of those professionals. They did not foresee her killing herself. As such, it was the cause of death rather than the death itself which came as a surprise to professionals.

3.3. This is not to say that in concluding the reviews a complacent attitude was taken of inevitability in the face of Maggie’s death. Services have reviewed their work and as set out above found examples of excellent work to help Maggie beyond what might have been considered acceptable, especially in a developing climate of financially stretched and under resourced public services.

3.4. There were few warnings of domestic abuse in the seven years prior to her death. There were three incidents when she was known to have been assaulted by Jim Trainer, in 2010, 2014 and on the day of her death. There were also behaviours by Jim which some saw as controlling and coercive. She did also admit to professionals that violence was mutual between her and Jim, or deny that any happened at all.

3.5. In terms of wider issues, good practice identified in this report includes the-

- Outreach service from the GP surgery to St Paul's to make GP services more available to those in need.
- Dedicated mental health professional running drop in clinics for the residents at the accommodation. This service remains at St Paul's but is now only for rough sleepers as residents are encouraged to register with a GP. A more flexible approach to include residents on a short-term basis until they are willing/able to register with a GP may benefit such vulnerable people as Maggie who are suffering domestic abuse and mental health issues.
- Work by the social worker to ensure staff at the accommodation were kept up to date with Maggie's situation despite software systems that were not accessible to all.
- Significant efforts by treatment workers to get Maggie in to detox facilities. She was to use her dog, and its being looked after during her detoxification, as reason for not engaging in the service.

4. Predictability and preventability

Whilst there were serious concerns held by professionals for Maggie over the years, deriving from her chaotic lifestyle, frail health and substance misuse the review did not find any information that would suggest her suicide was foreseeable. Neither were any alternative courses of action identified that may have prevented it. It is not even clear if she did wish to take her own life that day. She deliberately put the knife to her own throat to coerce her partner into seeking illegal drugs for her, but she may not have intended to deliver the cut to her jugular vein which caused her death.

5. Key Issues

The reviews identified some shortcomings in the way multi-agency meetings are held in Bournemouth and the information collated and subsequently disseminated. There were examples of non-attendance, actions not being checked for completion and information not being shared down to worker level due to a lack of understanding of what to do with the information or it being overly restricted in its protective marking. The agencies cover large areas and travelling time to and from physical meetings is wasteful of the time they have available to deliver their services.

5.1. Whilst some meetings are conducted via telephone conference facilities, further adoption of low cost IT solutions could improve attendance, information sharing and free up worker time in agencies that have seen a significant reduction in staffing levels in recent years. It may also allow a better option for the likes of GP's who find difficulty in leaving their surgeries for long periods in the middle of the day, yet they have a wealth of information about the person concerned, as they did in this case with Maggie.

5.2. There was some evidence of information not being shared around agencies, sometimes due to systems that don't communicate with each other and sometimes due to overly protective access levels. Changes to IT may fix some of these issues and a less risk averse release of access to those who need it may prove fruitful. An approach to data sharing that enables it getting to those who need it, rather than restricting it unnecessarily, can only help with critical decision making and reduce risks to those people that agencies should be working to safeguard.

5.3. Work has been done in other areas that shows most lessons that have been drawn for DHR's such as this often include the need for better information sharing and also further training in understanding domestic abuse. Those two issues have been identified here also. To prevent future reviews continuing to find the same issues there may be two approaches-

- A significant investment nationally to improve information systems across agencies. This may be hard to fund in current times of austerity and therefore a continued framework of disconnected standalone databases that cannot talk to each other will remain the norm. Consequently, better multi agency working and an effective meetings programme, based on an acceptance of the IT inadequacies, should be worked upon.
- The concept of having one named lead agency/Single Point of Contact for each complex individual identified as being most at risk would allow a situation where one person/supervisor can see all the risk and make proper plans to address them, with the help of partner agencies. Separate agencies conducting risk assessments in silos without the knowledge or consideration of useful information held elsewhere is not helping the person receiving their services. Ensuring all information on key individuals goes to one

person/agency is achievable even with the current stand-alone IT systems. Such an approach could actually reduce the number of agencies involved in the same level of service provision, which can only be of benefit to agencies that are increasingly resource strapped.

Each agency who completed an IMR also completed a single agency action plan for implementation of identified improvements to their systems to help future victims (the Joint Agency Action Plan can be found in the Overview Report as Appendix D).

6. Broader issues

6.1. Learning for Bristol/Bournemouth Community Safety Partnerships

1) The last several years have seen a significant reduction in staffing levels across all agencies involved in this review. Whilst that is not seen as leading to any failings in provision of services in this case, it did cause issues. This includes for example, changes in staff levels and consequent availability of services. In this situation, it would be timely for the Community Safety Partnership to consider how it prioritises and delivers its services, and those for whom it can no longer provide. This work may already be under way, but needs to be ongoing to address the ever-increasing complexities of those who require the services and to be able to provide sufficient service provision to those most in need within newly restricted budgets.

2) There was difficulty accessing information from some commissioned bodies that had been replaced when their commissioned period ended. I understand that such bodies are required as part of their contract to be able to provide access to information once their commissioning period is over. In some identified cases in our review, bodies were unwilling or unable to do this. When the local authority commissions a body to provide a service they must make it an enforceable position that information continues to be available. It caused some hindrance to this review but there are much wider and important issues for professionals being able to access all information held across service providers, whether current or no longer so.

3) A full root and branch review should be carried out of how multi-agency meetings are established and run. There was clear evidence of non-attendance and also for those that did attend, examples of a lack of understanding of what could, and should, be done with information received. Meetings should be established to allow people to attend. Actions raised at meetings were on occasions not completed or it was not possible to tell if they had been due to poor record keeping and lack of formal checking. Other actions such as 'monitoring' were written in the passive as opposed to setting pro-active steps to mitigate risk. A review by Bournemouth CSP of current practise in relation to multi-agency safeguarding meetings would be advantageous to allow understanding and if necessary to change practices to improve safeguarding work. The Review Chair understands that this point has arisen in two other ongoing DHR's in Bournemouth and the review panel are pleased to note this proposed work has already commenced.

4) There was evidence of risk assessments being carried out at various points by individual agencies to address the needs for individuals and to identify that multi-agency work was required. A more comprehensive approach with a single lead agency being identified to collate and manage the risk for the most complex of individuals would be beneficial. This may actually allow a reduced number of workers to be involved in overall service provision. The MARAC process goes some way to addressing this but perpetuates individual agency work and does not seem to identify the most appropriate agency or professional to coordinate and manage risk. Ownership by one identified professional/agency, who can be the recipient of all relevant information would allow for much better quality of risk management and therefore service provision. Given the demands of such a role it would perhaps only be achievable for those service users identified as being most at risk.

5) For the Borough Council when commissioning Drugs Treatment Services to consider a Harm Reduction Model of service provision as opposed to solely a Recovery Model. In cases such as this, addressing Maggie's all round risks may have benefitted her greater than a focus on providing the correct drugs. This approach would be in keeping with current thinking in the field, and it is

about reducing the harm of the substance abuse rather than medicating a reduction. (Department of Health document, Drugs Misuse and Dependence, UK Guidelines on Clinical Management, July 2017)

6.2. Regional or national issues identified

1) This review was initiated on Home Office Guidelines despite the fact that it was a suicide, rather than a homicide. If this is to be continued practise, it is requested that the Home Office review both the title of such reviews and the content of its Guidance document. A more fitting title, such as “Domestic Abuse Related Death Review” would be more accurate and also prevent the situation of raising doubt in the minds of the deceased’s family who, having come to terms with the suicide of their loved one, are informed that a review is to be carried out of the ‘homicide’. Such a change in title could be mirrored in a Guidance Document that makes it clear that references, contained within it, to ‘perpetrator’, relate to a domestic abuser who may or may not have been involved in the death.

2) As part of the consideration of the DHR process, greater flexibility could be given to Community Safety Partnerships to only review those suicides where Domestic Abuse appears to have been a significant and primary influencing factor on the decision of the person to take their own life. This may require some initial scoping work in establishing motivation, but would fall short of the sometimes cumbersome, time consuming and financially challenging processes of a full DHR review. This would allow a focus for DHR’s only to be conducted for those most troubling of deaths where there is most likelihood of, and need for, significant learning. It would also mean that time and money that could be devoted to supporting current victims of Domestic Abuse are not being unnecessarily devoted to costly and time consuming historical reflection that will produce little learning.

3) The Guidance also includes direction for Chairs/Panels to contact the perpetrator. Whilst the benefit of the insight they could provide may be very valuable, it is difficult in the case of suicide, where the perpetrator in the death of the deceased, is the deceased. To seek out and engage with a perpetrator responsible for the domestic

abuse of the deceased during their life is made difficult by Data Protection legislation as in this case, where there was a reluctance to release details to the Independent Chair, of the new address for the partner who played no part in the death.

(The Joint Agency Action Plan to implement the recommendations can be found in the Overview Report at Appendix D).

6.3 Summary of Recommendations

- Adoption of low cost IT solutions could improve attendance, information sharing and free up worker time in agencies.
- Full review is carried out of the multi-agency meeting structures in Bournemouth including how and when they are run, information sharing and dissemination from them, and action management.
- The Community Safety Partnership to consider how it prioritises and delivers its services, and those for whom it can no longer provide.
- A more comprehensive approach with a single lead agency being identified to collate and manage the risk for the most complex of individuals.
- Ownership by one identified professional/agency, who can be the recipient of all relevant information would allow for much better quality of risk management and therefore service provision.
- For the Borough Council when commissioning Drugs Treatment Services to consider a Harm Reduction Model of service provision as opposed to solely a Recovery Model.
- The Home Office review both the title of such reviews and the content of its Guidance document.
- As part of the consideration of the DHR process, greater flexibility could be given to Community Safety Partnerships to only review those suicides where Domestic Abuse appears to have been a significant and primary influence on the decision of the person to take their own life.