Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Kathie
in August 2018

Report Author: Christine Graham
October 2020

Preface

Middlesbrough Community Safety Partnership wishes at the outset to express their deepest sympathy to Kathie's family and friends. This review has been undertaken in order that lessons can be learned from the awful events of August 2018 to better protect others in the future.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances that led to Kathie's death in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by Middlesbrough Community Safety Partnership on receiving notification of the death of Kathie in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Contents

Section One – The Review Process

1.1 Introduction and agencies participating in the Review

1.1.1 This summary outlines the process undertaken by the Middlesbrough Community Safety Partnership Domestic Homicide Review Panel in reviewing the death of one of its residents. The death occurred in August 2018.

1.1.2 The victim in this case was Kathie who was 36 years old when she was murdered by a man who had been an intimate partner and from whom she was seeking to end the relationship. She was the mother of two young children and had divorced from her husband, the children's father, a few years prior to her death. In the years immediately preceding her death, she had struggled with alcoholism but had taken steps to address this and was on a recovery journey with local Alcohol Services. She had become close friends with the man who murdered her whilst they were both in the same residential rehabilitation centre. After they both left the centre, they formed an intimate relationship. Kathie was found dead in his flat and he was arrested for her murder. He pleaded not guilty to that murder but after a trial was convicted and sentenced to a term of life imprisonment.

1.1.3 The Middlesbrough Community Safety Partnership was notified by the death by the Police Service within two weeks of the discovery of Kathie's body. A meeting of partner agencies determined that the criteria for a review had been met and took the decision to commission the review within one month of Kathie's murder. The Home Office were notified of the decision two days later.

1.1.4 An Independent Chair and Report Author were appointed in November 2018 to undertake the review. As the judicial process had not been completed, the review opened but progressed in limited scope. The panel met four times; the final meeting of the panel was held in September 2020. In addition, there were individual meetings with service providers and the Independent Chair and Report Author; and additional meetings between the Independent Chair and Report Author and the CSP representative.

1.1.5 Once agreed by the DHR panel, a draft report was shared with members of Kathie's family who were supported by AAFDA and a solicitor. As a result of their feedback a series of changes and iterations were made before being agreed in the summer of 2021.

1.1.6 The review was not completed within six months as it could not commence, in full, until after the criminal process and it took time to gather information from the different medical organisations. This process was further delayed due to the Covid 19 lockdown as the decision was taken to enforce a necessary pause in the process during lockdown 1 for all agencies to come to terms with the additional pressure and new ways of working.

1.2 Contributors to the Review

1.2.1 The following individuals and agencies contributed to the review:

- Change, Grow, Live (CGL) – a substance misuse provider
- Cleveland Police

- Durham Tees Valley Community Rehabilitation Company (DTV CRC)
- Foundations – a substance misuse provider
- Humankind – Supporting people in Middlesbrough to live independently
- Middlesbrough Borough Council – Adult Social Care
- My Sister's Place – Providers of specialist domestic abuse services in the area
- NHS South Tees Clinical Commissioning Group on behalf of Kathie's GP
- Recovery Connections – a substance misuse provider
- South Tees Hospitals NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
- Middlesbrough Borough Council – Domestic Abuse & Sexual Violence Lead
- Middlesbrough Borough Council – Public Health

1.2.2 The perpetrator was invited to contribute to the review. He initially agreed to meet with the Chair and Report Author but then stated that he wanted to speak on the phone first. It then became clear that the perpetrator was maintaining his innocence, as he had throughout the trial, and that he was planning to appeal. At this point, the Independent Chair and Report Author decided that, in view of a pending appeal, and his declaration of his innocence, it was unwise to engage with him any further

1.2.3 Members of Kathie's family engaged fully with the process, they attended a panel meeting and posed several questions that this review has sought to address. They have been fully engaged in the drafting process.

1.3 The Review Panel Members

1.3.1 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Vicky Franks	Project Manager	CGL
DI David Glass	Complex Exploitation Team	Cleveland Police
Kay Nicolson	Deputy Director of Operations	DTV CRC
Nicole Clark	Partner: Quality and Performance	Foundations
Karen Thompson	Project Manager	Humankind
Claire Moore	Domestic Abuse and Sexual Violence Lead	Middlesbrough Council
Erik Scollay	Director of Adult Social Care and Health Integration	Middlesbrough Council
Rachel Graham	Family Practitioner – Family Partnership Team	Middlesbrough Council
Lisa McGovern	Support Service Team Leader	My Sister's Place
Ricky Vasey	Rehab Team Manager	Recovery Connections
Richy Cunningham	Regional Manager	Recovery Connections
Joanne Gamble	Designated Nurse, Safeguarding and Looked After Children	South Tees CCG

Helen Smithies	Assistant Director of Nursing (Safeguarding)	STHFT
Rhona Bollands	Assistant Director Children's Social Care	Stockton Borough Council
Karen Agar	Associate Director of Nursing (Safeguarding)	TEWV
Vicky MacDonald	Senior Nurse, Safeguarding Adults	TEWV
Janice McNay	Senior Governance and Compliance Manager	Thirteen Group
Ann Powell	Head of Cleveland NPS	National Probation Service

1.4 Domestic Homicide Review Chair and Overview Report Author

1.4.1 The Independent Chair for this Review process was Gary Goose MBE. The Overview Author was Christine Graham. Christine and Gary have both completed Home Office approved DHR training and their qualifications and training resume is detailed within the body of the main report. Both have undertaken multiple DHRs across the Country. Neither Christine nor Gary have been employed by or otherwise engaged by any agency within this Review.

1.5 Purpose and Terms of Reference of the Review

1.5.1 According to the statutory guidance, the purpose of the Domestic Homicide Review is to:

- 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
- 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
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to 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 possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.5.2 The Review Panel agreed that the specific purpose of the Review is to:

- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident, suggesting changes and/or identifying good practice where appropriate.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

Section Two – Summary chronology

2.1 Kathie was a white British woman who was 36 years old at the time of her murder. She had two children from a previous relationship. She experienced low mood and started to consume alcohol in 2013. Her alcohol consumption increased in 2015 following the breakdown of her marriage: now drinking on a daily basis. Kathie also had an addiction to codeine which had developed following a back injury some years previously.

2.2 Notwithstanding her illness, Kathie's children remained at the centre of her life. Whilst Kathie struggled with her increasing alcohol dependency, the children visited her when she was living in care homes and in residential rehabilitation.

2.3 It is clear that Kathie actively sought help and support for her alcohol addiction and engaged positively with substance misuse services culminating in a stay in residential rehab accommodation which began in December 2017. It is whilst in this residential rehab that she met this perpetrator, a man who had also been given residence by services treating him for his own alcohol addiction.

2.4 The words of the Judge when sentencing in this case are so pertinent that they deserve repeat here:

'It was her (Kathie's) misfortune ever to meet you'.

2.5 The perpetrator in this case was a man with a significant criminal history, including serving a sentence of 4 years imprisonment for robbery and was a man prone to threats and intimidation, including threats and intimidation to a former partner.

2.6 The process of risk assessment that placed this man in residential accommodation with vulnerable females such as Kathie is central to this review.

2.7 Once in the accommodation together a relationship developed between the two. It is not possible to say whether this was an intimate relationship, but they did embark upon an intimate relationship when both left the accommodation in April 2018. Initially Kathie lived with her father but then moved into the perpetrators flat with him.

2.8 Their relationship was formally disclosed to services supporting them on follow-up visits as part of their on-going care.

2.9 In the few months that followed, before her murder in August, Kathie was clearly subjected to significant physical abuse by this perpetrator. On occasion being hospitalised. A range of services were involved in supporting her but evidence to support a prosecution was not considered to meet the level required to prosecute.

2.10 Kathie appeared to have made the decision to part permanently from him and in the weeks immediately before her murder had been looking at accommodation and progressing well in her alcohol treatment. It appears she returned to his flat, only days before she was killed, probably to collect some belongings and not expecting him to be there. What happened remains unclear but it is reasonable to assume that through either manipulation or intimidation, he managed to get her to stay at the flat where he then savagely beat her to death.

2.11 The circumstances that afforded them the opportunity to meet, in what was a regulated and supervised environment, and the support from services after Kathie left the residential rehabilitation centre are the focus of this review.

Section Three – Agency contact and information learnt from the Review

3.1 A Domestic Homicide Review is charged with looking for a trail of domestic abuse.

3.2 In this case both Kathie and the perpetrator had significant prior involvement with a range of agencies. In Kathie's case that involvement was supportive through her divorce and then through several agencies helping her with her alcohol addiction. That culminated in her stay in the residential rehabilitation centre where her friendship with this perpetrator grew.

3.3 In the case of the perpetrator, he was known to support agencies for alcohol addiction, but also to criminal justice agencies for a range of offending, including violence and domestic violence to previous partners. He was deemed suitable for residential rehabilitation which occurred at the same time as Kathie.

3.4 The whole circumstances surrounding this perpetrator's suitability for a mixed gender residential rehabilitation centre are integral to this review and addressed accordingly with this review. This includes, in particular, any threat he posed to other residents as a result of his coercive behaviour.

3.5 After they both left the residential aspect of their treatment, they became involved in an intimate relationship which included several reports of serious assault and threat by this perpetrator towards Kathie. The level of evidence gathered following these reports meant that criminal prosecution of this perpetrator did not materialise however, efforts were made to work with Kathie to safeguard her. There is evidence that these efforts were partially successful as she seemed to have ended the relationship with this perpetrator and was looking at new accommodation.

3.6 Nobody will ever know why she ended up back his flat on the day of her murder, but it is possible that she went back to collect some belongings, not expecting him to be there.

3.7 This Review has carefully considered the trail of abuse, the opportunities to better intervene and safeguard Kathie and what can be learnt from this awful case. It has made several recommendations to better protect others in the future.

Section Four – Key issues arising from the Review

4.1 Multi-agency meetings that were held prior to this perpetrator's place in residential rehabilitation were not effective in sharing sufficient information to properly identify the risk that he posed of developing unhealthy relationships within that setting.

4.2 The Review has considered the issue of mixed gender residential rehabilitation and does not conclude that it is inappropriate per-se. However, much more must be done to ensure that predatory perpetrators such as this are recognised for the danger that they present. This review does however note and recognise the difficulties in justifying the release of such information in what is, after all, a health care setting and not a criminal justice placement. The review has identified good practice in another sector and has suggested that similar processes are adopted by drug services.

3.3 At the time of Kathie's murder there were delays in both the timeliness of the MARAC process and a process to consider Clare's Law disclosures. The review notes the improvement in both these areas and has made recommendations to ensure that improvement is maintained.

Section Five – Lessons Identified

5.1 **Cleveland Police**

5.1.1 The review notes that several changes have now been made to the process to ensure that the two meetings work together effectively and efficiently. For example:

- The MATAC co-ordination and MARAC screening are undertaken by the same person
- There are monthly meetings between Protecting Vulnerable People Support Hub and MARAC

5.1.2 Officers who are investigating domestic abuse cases should monitor their ongoing cases so that they can identify any new relationships that victims/perpetrators may enter so that early safeguarding referrals can be made.

5.1.3 Referring victims to specialist services may lead to them feeling able to support a police investigation.

5.2 **DTV CRC**

5.2.1 A lack of response to concerns relating to risk of harm, specifically in relation to domestic abuse and that information and assessments were not reviewed contextually.

5.2.2 Assessments were not updated after significant events.

5.2.3 Record-keeping was not, at times, contemporaneous.

5.2.4 Multi-agency working was not always co-ordinated and holistic in nature.

5.2.5 Unconscious bias and overfamiliarity led to a lack of focus.

5.3 **GP surgeries**

5.3.1 Patient records would benefit from more information being recorded, such as details of family, partners and children.

5.3.2 Patient records would be improved by a record of any discussions about alcohol misuse being recorded, along with any subsequent referrals and risk assessments.

5.3.3 Those surgeries would benefit from the development of a Domestic Abuse Policy and staff training in relation to domestic abuse.

5.4 **MARAC**

5.4.1 That, as the first point of contact for many patients, MARAC information needs to be shared with GP practices so that potential risks can be flagged.

5.5 **Middlesbrough Recovery Together**

5.5.1 Evidence of considerations of risk and vulnerability should form part of the services documentation to ensure that both aspects are properly considered and continually reviewed in light of emerging information.

5.6 **Recovery Together**

5.6.1 There is a need to review some of the policies and procedures of the organisation in light of the findings of this review.

5.7 **Adult Social Care**

5.7.1 There needs to be more ownership of cases, with a named person having a level of oversight of the case and ensuring that it is progressing appropriately.

5.8 **Thirteen Housing Homeless Service**

5.8.1 Thirteen Group needs to proactively engage with the domestic abuse agenda, ensuring that they are engaged in the processes and staff are confident with their understanding of domestic abuse.

5.9 **Links to other learning reviews in the local area**

5.9.1 This review has been cognisant of other safeguarding/learning Reviews undertaken in the local area and in particular the 'Lessons Learned Review concerning Adult C[1]'. This review has identified several similar areas of learning – particularly relating to domestic abuse and alcohol abuse – and it urges the local partnerships to ensure that this report is taken into account when progressing the learning across this and other previous reviews.

Section Six– Recommendations

Middlesbrough Recovery Together

6.1 That the risk assessment process should be improved to ensure that, when additional information becomes available, the risk assessment should be revisited.

6.2 That clearer documentation is introduced to demonstrate the consideration of the risk posed by a potential client and the decision-making process.

Foundations

6.3 That Foundations undertakes refresher training with all staff about MARAC aims and procedures.

Recovery Connections

6.4 That a review of case recording is undertaken by Recovery Connections and training should be considered for all staff to ensure a consistent approach across the organisation.

6.5 That Recovery Connections reviews the process for contact/escalation to other statutory services outside of non-working hours, particularly at weekends, and cascades this to all Recovery Connections staff.

6.6 That a review of the effectiveness of the pathway is undertaken.

6.7 That the risk assessment process should be improved to ensure that a comprehensive risk assessment is undertaken and is reviewed periodically, particularly if additional information becomes available.

[1] https://www.tsab.org.uk/key-information/safeguarding-adult-review-sar-reports/

6.8 That clearer documentation is introduced to demonstrate the consideration of the risk posed by a potential client, including risk to themselves, others and the community, and that professional judgement and decision-making in relation to this is documented.

Cleveland Police

6.9 That weapons markers are always placed on subjects following arrest or conviction, where appropriate.

6.10 That a review is undertaken of MARAC to establish if the aims of the changes have been met and the quality of MARAC and MATAC has improved.

DTV CRC

6.11 That the Operational Minimum Standards (OMS) for all practitioners are monitored and supervised by each manager, with each staff member, every month.

6.12 That current MARAC processes across DTV CRC are reviewed and that a standardised approach is introduced.

GP practice for both the perpetrator and Kathie

6.13 That the quality of primary care documentation includes any discussion with the patient relating to alcohol misuse and any subsequent actions such as referrals and risk assessment.

6.14 That information is included in the 'relationships' section on partners (including ex-partner, children and other family members).

6.15 That the practice explores processes that support risk assessments of patients who are known to have alcohol (and other) dependency and the impact on relationships and parenting ability. This should also provide an opportunity to assess if further support could be given to improve the management of their dependency and promote positive outcomes.

6.16 That all practice staff are up to date and competent with safeguarding training.

6.17 That a Domestic Abuse Policy is developed for the GP practice and that this is audited to assess the knowledge of staff in relation to domestic abuse

6.18 That consideration is given to how MARAC information can be shared with GP practices so that practices can consider if it is appropriate for primary care records to be coded and flagged to identify potential risk to others.

Clinical Commissioning Group

6.19 That consideration is given to how the learning from this DHR is disseminated to other GP practices in the area.

Adult Social Care

6.20 That outcome information from the police, and other agencies, should be sought within agreed timeframes.

6.21 That every case has a contact point – a person who provides a level of oversight of the case.

6.22 That when information or a referral is received, it should be cross-referenced by a qualified social worker, with previous history and consideration for any action required. This should be discussed with a senior social worker when necessary.

Middlesbrough Community Safety Partnership

6.23 That Middlesbrough Community Safety Partnership reviews the implementation of the Integrated Commissioning Model to assure itself that the issues identified in the way in which Kathie was dealt with have been eradicated.

6.24 That Middlesbrough Community Safety Partnership seeks assurance regarding the implementation of MEAM approach in Middlesbrough and if it has driven system change and improved outcomes for vulnerable women.

MARAC

6.25 That a review is undertaken to establish if the aims of the changes have been met and the quality of MARAC and MATAC has improved.

Section Seven – Conclusions

7.1 The words of the Judge, when addressing this perpetrator and sentencing him for this horrific murder, frame the context of this review. In particular, the phrase, **'Her tragic misfortune was to meet you'.**

7.2 This is a case that highlights, again, the real danger that women face at the hands of manipulative and violent men, especially at the point of separation.

7.3 The victim's vulnerability to manipulation, control and violence was exacerbated in this case by her struggles with alcohol and her steps to regain control of her life. The judge recognised Kathie as being on the 'slow road to recovery'.

7.4 This review has considered the circumstances of Kathie meeting this perpetrator and how the relationship developed. It has looked to find the trail of abuse and, in particular, where lessons can be learned to better protect others in the future.

7.5 The review has identified a number of areas from which the tragedy of this case must be acted upon to improve the safeguarding of women like Kathie.

7.6 In the examination of all of the facts of this case, one thing remains clear: there is only one person responsible for Kathie's death and that is this perpetrator. That fact must not be forgotten.