SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Victim: Kathleen

CONTENTS

1. INTRODUCTION

1.1 The principal people referred to in this report are:

Kathleen	Victim	White British
Louise	Perpetrator (19 years)	White British

1.2 In 2014 Kathleen was strangled to death by her daughter Louise. She was charged with murder and later that year a jury found her not guilty of murder but guilty of the manslaughter of Kathleen. Louise was sentenced to 56 months imprisonment.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Decision Making

2.1.1 Sefton Safer Communities Partnership decided that the death of Kathleen met the criteria for a DHR. David Hunter was appointed as the Independent Chair and Author. He has chaired and written previous DHRs and kindred matters. The Panel comprised representatives from local agencies and additional independence and domestic abuse expertise was provided by the Chief Executive of Sefton Women's and Children's Aid [SWACA] a local domestic abuse service.

2.2 Material seen by the Panel

2.2.1 Four agencies submitted Individual Management Reviews [IMR] and others provided chronologies and information when requested.

2.3 Involvement of Families

2.3.2 Kathleen's family and a number of people known to Kathleen and Louise as friends, colleagues and associates have been spoken to. Kathleen's family believe that Louise concocted a story for the jury that painted her mother in a very bad light which was done to prevent Louise being convicted of murder. The independent author saw Louise in prison and relevant information from the contacts is included in the report and attributed where appropriate.

2.4 Terms of Reference

2.4.1 The purpose of a DHR 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, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

[Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7]

3. BACKGROUND

3.1 Louise's father left the family home when she was about six months old. Kathleen bought up Louise as a single parent and thereafter was in an abusive relationship with another man until she found the strength to terminate it. Kathleen worked as a hospital cleaner. She lived alone with Louise. There was no indication from a work perspective of any concerns about domestic abuse.

3.2 David Hunter saw Louise in prison. She disclosed a fairly difficult and sometimes traumatic relationship with her mother. Louise said she witnessed domestic abuse between her mother and boyfriend. Louise said when her mother was not under the influence of drink she "was proper lovely" and they had some very good times together. Louise expressed remorse for her actions and hoped her family could forgive her.

3.3 Kathleen's family recognised she misused alcohol but did not know the extent. Her death has left a void in the lives of her family. They believe her voice as a victim of domestic abuse was not heard or listened to when she was alive and that the DHR provides an opportunity for redress. They describe Kathleen as a warm and generous person who would never turn anyone away who was in need of help. She provided food and accommodation without judgement and would never make you feel embarrassed or that you had imposed on her. The family said that Kathleen had a strong character but felt she hid too much of her personal life from them.

3.4 Kathleen's misuse of alcohol was known to her GP and attempts made to address it although there appears to have been no exploration with her as to the reasons why she drank excessively. Neither was there any exploration of the impact her misuse of alcohol was having on her daughter. However Kathleen was referred by her GP to a specialist service to address her misuse of alcohol. The GP did not make a referral to adult social care.

3.5 Louise's behaviour from her enrolment at Southport College in 09.2012 until 30.09.2013 did not raise any concerns which would suggest there were

significant issues between her and Kathleen during this time. During the autumn of 2013 the relationship between Kathleen and Louise seemed to deteriorate and Louise disclosed to friends and to staff at the College that her mother was drinking heavily, and that she had an unhappy home life. Information was also received within the College from a friends of Louise's that Kathleen had struck Louise on the arm. The alleged striking cannot be independently verified.

3.6 Louise claimed she did not drink although there were two episodes when she became intoxicated and a single occasion when she took an overdose. This incident happened on 24.10.2013 and Louise claimed Kathleen encouraged her to repeat it. No formal domestic abuse risk assessments were undertaken in respect of the relationship between Kathleen and Louise and no co-responsive violence screening took place to determine what was happening in the home. Therefore it is not possible to say objectively what the exact nature of the relationship was and whether one person was dominant over the other. However, it is a fact that Louise was responsible for her mother's death.

3.7 Southport College staff engaged with Louise, provided counselling services, signposted her to other services and believed that, as she was 18, this was the action that was necessary. They shared information with Sefton Supported Lodgings, with the Hesketh Centre, with children's services and with the family centre in an attempt to understand Louise's situation. The panel believe that was good practice.

3.8 On 28.11.2013 Kathleen took an overdose following which she was admitted to hospital. During that process she disclosed to the paramedic attending her that Louise had threatened to kill her. The paramedic did not believe this to be a recent or immediate threat and did not explore it further. The panel believe this was a reasonable belief.

3.9 While at the hospital Kathleen saw an alcohol specialist nurse who identified that Louise was a protective factor for Kathleen. Had the specialist nurse been aware of the admission of Louise a month earlier, after taking an overdose herself, that information may have led them to probe deeper into the relationship between Kathleen and Louise. This might have led to a different conclusion in relation to the suitability of Louise as a protective factor. The panel believes this suicide attempt by Kathleen was controlling behaviour and may have been an attempt to stop Louise leaving.

3.10 This event seems to have coincided with the period when Louise was trying to find alternative accommodation so as to escape from Kathleen's drinking. As a result of that incident Kathleen engaged with Lifeline (a drug and alcohol service) stating that she wanted to address her habit. A risk assessment was carried out although this considered the risk to Kathleen from her former partner, but not from Louise. Given Lifeline had no information at that time to suggest there was any risk to Kathleen from Louise that was a reasonable step to take. At the same time Louise made a

decision not to leave home and instead told the College that she was staying to look after her mother.

3.11 The panel discussed these events and whether, had the relationship between Kathleen and Louise been an intimate one as opposed to mother/daughter, organisations may have responded differently. They believe this case highlights that professionals need to understand there are different aspects to domestic abuse. These include controlling behaviour that does not always present in the context of an intimate relationship between opposite or same sex partners.

3.12 Despite Kathleen's attempts to remain abstinent, which were partially successful, it appears she engaged in a significant bout of drinking over the Christmas period. On 02.01.2014 she contacted Lifeline and told them about her drinking together with the fact that Louise had tried to smother her. Staff at Lifeline dealt with the disclosure by advising her to report the matter to the police but she declined and insisted it remain confidential. Lifeline staff and management took a conscious decision not to breach this confidentiality believing instead they could put measures in place to protect Kathleen.

3.13 The panel believe this case presented grounds upon which Lifeline should have breached the right of Kathleen to confidentiality. However they felt it was important to complete the analysis based on what was known at the time and against the contemporary policies and operating framework, as opposed to hindsight. The "reasonableness test" was applied and the panel believe that the member of staff at Lifeline who received the information from Kathleen did not appreciate the potential magnitude of what they were being told and neither did the manager who was consulted.

3.14 Matters escalated during the following days and there is evidence that Kathleen and Louise argued and that Louise told friends about the behaviour of her mother. Kathleen's sister described a telephone conversation with her in which she said that Louise tried to smother her with a pillow shortly before Christmas 2013. Kathleen said she found it very difficult to fight Louise off. Kathleen said that Louise then got a second pillow and was using the two pillows to smother her and then attempted to push her into a cupboard. Kathleen told her sister she was frightened to death of Louise who constantly berated her. She also told her sister she would deny anything had happened if the police were involved. The conversation was not reported to the police.

3.15 Kathleen left a message on Southport College answering machine disclosing that Louise had attempted to smother her. During that same evening Louise actually carried through that act and killed her mother. It is clear the College had no opportunities to respond to that call as it was closed when the call was made. Nor did they have any evidence or indication during their conversations and dealings with Louise that she had attempted or was contemplating such an act. The panel believe there is no evidence to support

Kathleen's claim in that message that the College were giving Louise the wrong advice. All the evidence appears to confirm Southport College were trying to signpost Louise towards what they believed were the right services.

4. LESSONS IDENTIFIED

4.1 The IMR agencies lessons are not repeated here because they appear as actions in the Action Plan at Appendix 'B'.

4.2 The DHR Lessons Identified are listed below. Each lesson is preceded by a narrative.

1. **Narrative:** Kathleen was an adult with vulnerabilities because she was in receipt of services. There was a failure to recognise that the disclosures she made to staff at Lifeline concerning the attempt to smother her by her daughter Louise (02.01.2013) amounted to a serious criminal offence and was therefore both an instance of domestic abuse and of abuse of a vulnerable person within the terms of the Sefton Safeguarding Adults Policy and Procedural Framework for Action 2011.

   Lesson

   Failure to recognise when the serious nature of a crime committed or suspected overrides the confidentiality wishes of a vulnerable person means that policies on abuse are not correctly applied thereby denying agencies the opportunity to assess and address abuse.

2. **Narrative:** Kathleen and Louise both had contact with agencies for issues that were either caused by their relationship as mother and daughter or impacted upon that relationship. Some of the behaviours displayed by both Kathleen and Louise amounted to domestic abuse as defined in the Government's definition. However agencies did not recognise that indicators of domestic abuse were present.

   Lesson

   Had the relationship between Kathleen and Louise been an intimate one as opposed to mother/daughter, organisations may have responded differently. This case highlights that professionals need to understand there are different aspects to domestic abuse. These include controlling behaviour that does not always present in the context of an intimate relationship between a male and a female.

3. **Narrative:** Kathleen misused alcohol and this was known to health agencies including her GP and primary care who referred her to support services. However no agency appeared to adequately explore the roots causes of her misuse of alcohol nor the

consequences of it, which was the impact it was having upon her relationship with Louise.

Lesson

Agencies providing support to patients such as Kathleen who misuse alcohol should not view the issue in isolation and need to explore the impact such behaviour is having, not just on the patient, but also on the their relationships with others. Where there is felt to be an impact, as well as treating the root cause, interventions which address the harm their addiction is causing should be considered such as, for example family therapy or mediation.

5. CONCLUSIONS

5.1 This panel concluded on the information given by Louise that she was the victim of domestic abuse at the hands of Kathleen. Equally, the same information reveals that Louise was perpetrating domestic abuse on Kathleen. In coming to a conclusion on these issues the panel felt it was important to complete the analysis based on what was known at the time. They applied the "reasonableness test" and were careful to ensure the magnitude of the events did not prejudice their thinking. The panel concluded that, while there were missed opportunities to assess risk, the death of Kathleen was neither predictable nor preventable.

6. RECOMMENDATIONS

6.1 The Agencies and Panel recommendations appear at Appendix 'A'.

Action Plan **Appendix A**

Panel Recommendations						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Review domestic abuse policies, and work with partners to review their policies, so as to ensure it is clear when confidentiality can be breached and how suspicions of crime should be reported;	As part of Sefton's Domestic and Sexual Violence Strategy – work with key partners to review policies and procedures around safeguarding procedures and sharing information Started as part of mapping work September 2105 - ongoing	Updated policies and procedures	Consistent approach to information sharing when confidentiality must be breached for safeguarding reasons	Sefton CSP	March 2016
2	Review domestic abuse policies, and work with partners to review their policies so as to ensure that the circumstances in which behaviour amounts to abuse is clear and how it should be reported;	As part of Sefton's Domestic and Sexual Violence Strategy – support to partners about what domestic violence can involve: offer of training, staff briefing sessions Partners to review policies and procedures so training outcomes reflected in these Started as part of mapping work September 2105 - ongoing	Updated policies and procedures	Clear and Consistent referral pathways Clear and readily accessible information about services available in Sefton	Sefton CSP	March 2016
3	Work with partners to review their domestic abuse policies so as to ensure that direct questions are asked of those who abuse alcohol to establish if they present a risk of being a perpetrator or	As part of Sefton's Domestic and Sexual Violence Strategy – work with partners to highlight need for routine questioning Started as part of mapping work	Updated policies and procedures	Clear identification of domestic violence risk factors associated with alcohol misuse	Sefton CSP	March 2016

	victim of domestic abuse;	September 2105 - ongoing				
4	In delivering these recommendations reinforce to partner agencies the complexities of family violence within a domestic abuse framework. In doing so they should consider using the death of FA as a case study. It illustrates well that domestic abuse occurs in many different relationships between family members and not just between those who are, or have been, in an intimate relationship.	As part of Sefton's Domestic and Sexual Violence Strategy – development of 'Sefton offer' promotional info on domestic violence services; updated webpage on Council website – available www.sefton.gov.uk/behindcloseddoors Review of existing training opportunities available for partners across Sefton – to ensure highlights different forms of domestic abuse. Work started on this September 2015 – ongoing	Updated DV training programme Updated promotional information	Clear and readily accessible information about services available in Sefton Promotional information highlights the different forms of domestic abuse	Sefton CSP	Promotional Info completed Dec 15 March 2016
5	That agencies who are commissioned to provide services should be required to inform their Commissioners when they become engaged in a DHR and of any recommendations arising.	As part of Sefton's Domestic and Sexual Violence Strategy – Nhoods & Partnerships to work with Commissioning and contracts teams to consider how this could be done Initial conversations started and ongoing, particularly in relation to Public Health contracts.	Dependent on outcomes of discussions	Consistent approach to DHR involvement and learning	Commissioned Services within Sefton CSP area.	April 2017

Agency Recommendations- NWAS						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	To review Domestic Violence content for mandatory training.	Review Induction Training for all new staff and for bi annual mandatory training. Include indicators of domestic abuse and professional curiosity.	Updated mandatory training	Increase awareness of domestic violence and early intervention or support for patients at risk.	Vivienne Forster.	31/1/2015
2	Publish learning lessons from this review in the 'Clear Vision' Bulletin.	Write an article highlighting the importance of risk assessment and information sharing in relation to domestic abuse.	'Clear Vision' article	Increased staff awareness in relation to risks associated with domestic abuse and support guidance and supervision available to staff	Vivienne Forster	31/01/2015
3	Debrief and reflective learning with staff involved with Kathleen and Louise.	Arrange meeting to de-brief the staff in relation to this case with a focus on practice and lessons learned.	Evidence from Advanced Paramedic this has taken place.	Support to staff in a safe learning environment while learning and increased awareness of the issues occurs.	Vivienne Forster and Andrew woods (Advanced Paramedic)	31/01/2015

Agency Recommendations- Lifeline						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1.	Recommendation (internal and external) Lifeline to approach SWACA to see whether they can provide a training session to the team in Sefton – to (i) confirm the team's understanding of appropriate responses to disclosures of domestic violence, (ii) describe the support that they can offer and in the circumstances in which they can provide support, and (iii) support us to reflect on whether our usual responses to disclosures of domestic violence should be any different if the perpetrator is the victim's child, sibling, etc.	Within six months, approach SWACA to see whether they can provide a training session to the Lifeline Sefton staff team covering the three areas detailed in the recommendation. Organise staff availability and rotas to ensure the maximum number of members of the team are available for this briefing. Sefton Safeguarding and Governance lead to feed back any areas relevant to Lifeline's organizational understanding of domestic abuse to operational managers and Clinical Governance Lead	Within six months – either (a) notes and attendance records from SWACA training session, or (b) correspondence showing that SWACA were unable to provide training If there are any areas relevant to Lifeline's organizational understanding of domestic abuse, these will be incorporated into Lifeline's Safeguarding policy,	Increased awareness of appropriate responses to disclosures of safeguarding amongst the Lifeline Sefton Team. If identified, an improved organizational understanding of effective responses to domestic abuse cases that do not follow a male-female partners category	Lifeline Sefton Safeguarding and Governance Lead Lifeline Sefton Safeguarding and Governance Lead and Lifeline Clinical Governance Lead	16/12/14 31/12/14
2.	Review staff awareness of their role in responding to disclosures of domestic abuse, and confidence in fulfilling these roles – with individual development plans to address any	Within three months, undertake a review of staff awareness and competency in responding to disclosures of	Completed domestic abuse competency audit.	Assurance that all current staff are aware of their roles in responding to	Lifeline Sefton Safeguarding and Governance	16/9/14

	identified needs	domestic abuse within the Lifeline Sefton team. Identified developmental areas to be incorporated into personal development plans	Examples of personal development plans including developmental needs identified through this audit	disclosures of domestic abuse	Lead	

Agency Recommendations- Southport College

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1.	To have one central tracking document per student.	Develop and implement a new single tracking document for each student receiving support.	Tracking document will be held in each file.	The tracking document will provide an overview to anyone reviewing the student. It can be used to check and cross reference that all notes, messages etc listed are held on the file and identify gaps and/or any delays in follow up action.	Director of Quality and Support	October 2014

2.	Advice should be sought from the LCSB as to the appropriateness of key College staff having a Level 3 Safeguarding qualification.	Level 3 Safeguarding training to be completed by staff if it is considered appropriate and available from LCSB	Course completed	College staff are trained above the minimum requirements.	Director of Quality and Support	June 2015
3.	External supervision should be available to staff with safeguarding responsibilities.	College to source appropriate external supervisor.	Records of supervision meetings.	Staff feel supported and have an opportunity to off-load, discuss and review cases, share good practice and identify improvements/changes to existing practices and systems.	Director of Quality and Support	March 2015
4.	Implement a new model of delivering conduct, welfare and support in College. Review Student Services staff roles and functions and ensure roles are more clearly defined.	Review roles, responsibilities and delivery models for conduct, welfare and support and make appropriate structural changes.	Review completed.	Student Services roles more clearly defined. The priority of key staff with Student Services remains safeguarding cases.	Director of Quality and Support	March 2015

				Welfare and conduct matters are managed at source within curriculum departments.		

End Executive Summary