DOMESTIC HOMICIDE OVERVIEW REPORT

REPORT INTO THE DEATH OF KARA AND STEFAN

Report produced by:
Barnet Domestic Homicide Review Panel

Neil Blacklock, Independent Chair for the Review and the Report Author

Date 02.12.13

Contents

Section One: Context

1.1 Introduction

This is a report of a Domestic Homicide Review (DHR) that examines the circumstances leading up to the deaths of Kara and Stefan at their home on 22nd January 2013. Kara and Stefan are pseudonyms used throughout the report. The review will consider all contact/ involvement of agencies with Kara and Stefan from 21st January 2012 to 22nd January 2013 and any earlier contacts that had relevance for the work of the Review Panel.

1.2 Reason for conducting the review

Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act 2004 that came into force on 13th April 2011.

The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way local professionals and organisations work individually and together to safeguard victims and hold perpetrators to account
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted upon, 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 homicides and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3 Process of the review

I. This DHR was recommended and commissioned by the Barnet Safer Communities Partnership Board BSCPB, in line with the requirements of the *Multi-Agency Statutory Guidance for the Conduct of the Domestic Homicide Reviews 2011*[1].

II. Barnet Safeguarding Adults Board has decided that there is no cause to commission a serious case review with respect to Kara and Stefan.

[1] http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-violence/domestic-homicide-reviews/

The DHR Panel consisted of:

Name	Representing	Position
Neil Blacklock	Independent	Chair
Manju Lukhman	London Borough of Barnet (LBB)	Domestic Violence Co-ordinator
Tony Caetano	Metropolitan Police Service (MPS) Barnet Police	Detective Inspector, Public Protection
Paul Gardner	MPS	Critical Incident Advisory Team
Tim Spratt	MPS	Critical Incident Advisory Team
Kate Kennally	LBB	Director for People
Dawn Wakeling	LBB	Adults & Communities Director
Pam Wharfe	LBB	Director for Place
Teresa McHugh	Barnet & Chase Farm Hospital, NHS Trust	Deputy Director for Nursing
Terina Riches	Barnet & Chase Farm Hospital, NHS Trust	Director of Nursing
Richard Bell	LBB	Community Safety Team
Sue Smith	LBB	Safeguarding Adults Manager
Peter Wolfenden	London Fire Brigade LFB	Station Manager
Steve Leader	LFB	Borough Commander
Ruth Williams	London Ambulance Service	Community Involvement Officer
Annette Dhillon	Victim Support Service	Senior Service Delivery Manager
Roger Cornish	Barnet Clinical Commissioning Group	Interim Safeguarding Adults Lead
Emma Bell	Solace/Jewish Women's Aid	Director of JWA

The following agencies who had contact with Kara and Stefan were asked to secure their records and to identify an independent author of sufficient experience to undertake an individual management review (IMR).

London Borough of Barnet Adults and Communities
London Fire Brigade
London Ambulance Service
Central London Community Health Care
Family General Practice
Barnet and Chase Farm Hospital
Housing 21
London Borough of Barnet Planning, Conservation and Regeneration

Additional sources of information for the work of the Review Panel

I. Each IMR was scrutinised by the Panel and, where appropriate, IMR authors were invited to attend a Panel meeting to answer questions directly from Panel members. The staff from two organisations were interviewed by the

Chair and further information and clarification was sought from six agencies to support the Panel in its work.

II. The Chair also interviewed the members of staff at AB Women's Association who had contact with Kara by phone about their involvement. The Chair spoke by phone to solicitors L and Co, who had been consulted by Kara. The solicitors used by Stefan, did not respond to requests from the Chair to contribute to the Review.

III. A record of a consultation with Kara at the General Practice on the 24th January 2011 was recovered after the IMR was undertaken and after submission of the overview report to the Home Office Quality Assurance. This was made available to the Chair and Panel members and information from this is included in this report and the Home Office were informed.

IV. The Chair and author of the DHR overview report is Neil Blacklock, Development Director at Respect and has no previous involvement with the subjects of the Review. Neil has a background in developing intervention programmes for perpetrators of domestic violence. He was involved in establishing and managing the Domestic Violence Intervention Project between 1991 and 2006, before moving to Respect. While at Respect he has written the Respect Service Standards for organisations working with domestic violence perpetrators and leads on Respect's work with young people and on workplace responses to domestic violence.

1.4 Timescales

This review began on 4th March 2013 and was concluded on 2nd December 2013.

1.5 Terms of reference

The terms of reference agreed at the DHR Panel meeting includes the purpose of the Review as set out in section 1.2 and the scope of the Review which was to review the events in the twelve months up to the date of the deaths of Kara and Stefan and any relevant events outside of this time period.

In addition, the Panel was asked to focus on the following questions, with a particular focus on paragraph vi:

i. Was there was evidence of a risk of serious harm to the victim that was not recognised or identified by the agencies in contact with the victim and/or the perpetrator, not shared with others and/or not acted upon in accordance with recognised best professional practice?
ii. Do any of the agencies or professionals involved consider that their concerns were not taken sufficiently seriously or not acted on appropriately by the other parties involved?
iii. Does the homicide indicate that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or other procedures for safeguarding adults, including homicides, where it is believed that there was no contact with any agency?
iv. Whether the homicide appears to have implications/reputational issues for a range of agencies and professionals?
v. Does the homicide suggest that national or local procedures or protocols may need to change or are not adequately understood or followed?

vi. If the victim had no known contact with any agencies, could more be done in the local area or within specific communities to raise awareness of services available to victims or perpetrators of domestic violence?

1.6 Individual management review (IMR) authors

The DHR Panel received and considered the following IMRs:

Organisation	Author name	Author title
Housing and Planning	Pam Wharfe	Director of Place
London Fire Brigade	Peter Wolfenden	Station Manager
London Ambulance Service	Alan Taylor	Head of Safeguarding Adults
Barnet and Chase Farm Hospital	Teresa McHugh	Deputy Director of Nursing
General Practice	Roger Cornish	Interim Safeguarding Adult Lead, Barnet Clinical Commissioning Group
Housing 21	Debbie Fitzgerald	Care and Services Manager
Adults and Communities	Helena Peros	Specialist Social Worker (safeguarding adults)
Central London Community Health Care	Kate Bushell	Adult Safeguarding Lead

The Panel received written confirmation that Kara and Stefan were not known to have had contact with the Metropolitan Police Service, Solace/Jewish Women's Aid, Royal Free Hospital and Victim Support.

1.7 Development of individual management reviews (IMRs)

I. Individual management reviews form the backbone of the DHR and are expected to provide an accurate account of each agency's response to Kara and Stefan. They are also expected to reflect on this response and evaluate whether this was in line with their policy and procedure, whether that policy and procedure is best practice and, if necessary, put forward improvements for the future. The IMRs have also looked at changes in practice and policy that have occurred during the time frame of the review and considered the impact these have had on an agency's current response.

II. IMRs were seen by the Chair and scrutinised by the Panel as a whole. Some IMR authors were asked to present their reports to the Panel and the Panel sought clarifications and further evidence. On seven occasions, Panel members or the Chair requested additional information or clarification. Two phone interviews took place to follow up on IMR information to support the IMR author and the agency in reflecting on current practice and to aid the Panel in developing the recommendations to this report.

III. The Report's recommendations represent the consensus view of the DHR Panel and are the product of full and frank discussion of all the significant issues arising from the Review.

1.8 Confidentiality

I. The findings of each Review are confidential with information available only to participating officers/professionals. Following acceptance of this Report by Barnet Safer Communities Partnership Board, a confidential briefing note encapsulating the key messages and recommendations will be circulated to relevant managers in each of the agencies that contributed to this DHR.

II. The Report's recommendations attached to specific agencies have been shared with those agencies to enable them to make progress on these at the earliest opportunity.

1.9 Dissemination

I. While it is important that key issues arising from the review are shared with organisations that need to act on these so as to improve responses to domestic violence, the report will not be disseminated until clearance is received from the Home Office Quality Assurance Group.

II. In order to progress towards agreement on the contents of the Report, drafts were seen by the membership of the DHR Panel and relevant aspects of the Report were seen by the IMR writers as listed in 1.6 and the membership of the Barnet Safer Communities Partnership Board (BSCPB). The Chair and Panel discussed any points raised by IMR authors in order to achieve agreement, the report will state where this was not possible and what the exceptions were.

III. The content of the Report and its executive summary will be anonymised in order to protect the identity of all family members, staff and others and to comply with data protection requirements.

IV. The anonymised DHR Report will be published after clearance from the Home Office Quality Assurance Group. The recommendations from the Review have been incorporated into an action plan which will be followed up on by BSCPB to ensure that recommendations are acted upon and lessons from the Review are learned.

V. The overview report will be produced in a form suitable for publication and redacted in line with the framework set out in Appendix 3.

1.10 Subjects of the review

Deceased (victim female) referred to throughout the report by the pseudonym **Kara**

Deceased (perpetrator male) referred to throughout the report by the pseudonym **Stefan**

Both subjects are Greek Cypriot and aged 80 and 69 respectively

1.11 Family genogram (See Appendix Four)

1.12 Involvement with family and friends

I. In DHRs, the involvement of the family, friends and colleagues can provide an insight into the victim's experience. The Panel considered carefully the potential benefits of their involvement, as well as the demands this asks of them, and that the time frame of the review may not be the time that is right for them during a very difficult period.

In DHRs, the involvement of the family, friends and colleagues can provide an insight into the victim's experience. The Panel considered carefully the potential benefits of their involvement as well as the demands this asks of them. The Panel also considered that the time frame for this review may not be the right timing for them during a very difficult period.

II. The Chair of the DHR had been in contact with the daughter of Kara throughout the review and met with four friends of Kara and Stefan. A niece of Kara attended the review panel on 14 October 2013.

III. The contribution of the daughter and other family and friends of Kara and Stefan to the review process has been invaluable; the Chair would like to thank them for helping us to better understand the lives of Kara and Stefan.

IV. Kara's daughter saw the report prior to submission to the Barnet Safer Communities Partnership Board and the Home Office Quality Assurance Panel.

Section Two: Barnet Domestic Homicide Review Panel Report

2.1 Introduction

This review report is an anthology of information and facts from ten agencies, all of which were potential support agencies for Kara and Stefan or agencies with the opportunity to reduce the risk posed by Stefan.

The agencies that contributed to the review through IMRs are:

- Planning Service London Borough of Barnet (LBB)
- London Ambulance Service
- London Fire Brigade
- Adult and Community Services (LBB)
- Housing 21
- Barnet and Chase Farm Hospital NHS Trust
- General Practice for both Kara and Stefan
- Central London Community Health

Two organisations contributed to the review through interviews:

- AB Women's Association (pseudonym)
- L and Co Solicitors (pseudonym) - phone interview

Agencies that undertook a search of their records but had no recorded contact with Kara and Stefan were:

- Solace/Jewish Women's Aid also checked the previous service provider's (DVSS) records
- Metropolitan Police Service
- Royal Free Hospital
- Victim Support Barnet and Enfield

I. The risk to Kara was not identified by any of the professionals contributing to this review. The report highlights the need for professionals to be alert to the risk to older members of the community from domestic violence and that there needs to be an urgent consideration of when interpreters should be used in health settings.

II. Five of the above agencies – Adult and Communities, Housing 21, the Family General Practice, Central London Community Health Care and the Barnet and Chase Farm Hospital - had direct contact with Kara in the year prior to her death and had opportunities to identify and explore the risk to her. Kara was not known to Barnet's specialist domestic violence service.

III. AB Women's Association and L and Co Solicitors were agencies that Kara sought advice and support from in the last three years of her life.

In reviewing the IMRs and the contribution from other agencies there are concerns that language, cultural identity and age were a barrier to services or to an appropriate response such that agencies should make adjustments to their practice.

2.2 Summary of the case

I. Kara was 80 years old and 3 days away from her 81st birthday at the time of her homicide by her husband, Stefan, who was aged 69. Kara and Stefan had been married for 35 years and had been living separately within the family home for five years after dividing the house into two flats. Kara has one daughter from a previous marriage, who lives with her husband in the North of England and had regular and consistent contact with her mother. Both Kara and Stefan are Greek Cypriot and lived in London for most of their lives

II. Kara and Stefan married thirty five years ago. There are reports of Stefan's aggressive, abusive and violent behaviour towards his wife throughout their relationship, with incidents reported to the report author by family and friends and first recorded on 9th April 1987 in the medical record of the General Practice Kara was attending at this time.

III. From 1987 for a period of ten years Kara and Stefan moved to Greece to run their own bar and rented out the family home in Barnet, returning to London in 1997. There are reports from family that Kara continued to be subject to violence from Stefan while they lived in Greece. There are reports from friends that they would argue over Stefan having affairs and Stefan would sometimes unexpectedly leave without informing Kara, or without her knowing when he would return.

IV. Kara's daughter reported to the author that in her view Stefan's behaviour and mental health deteriorated from 2006. In 2008/9 Kara wanted to live separately from Stefan stating to friends that she had had enough of his behaviour towards her. In 2008 Stefan took steps to change the ownership of the family home so that they were tenants in common. In 2009 the house they shared was divided so that they had separate flats with two door bells, and lived separately.

V. Friends and family noticed that Stefan's behaviour seemed strange to them after Stefan changed his will preventing Kara or her daughter inheriting half of the family home. The daughter and family friends reported that he had become "obsessed" with the house. When asked why he had changed his will he said on a number of occasions, to different people, that his wife, her brother and daughter were going to murder him and that he had overheard them saying that "they were going to pay a black man £10,000 to kill him".

VI. The daughter of Kara reported her concerns about Stefan's mental state and behaviour to the family GP (GP1) in January 2011.

VII. GP1 followed up on these concerns with an appointment with Kara where she disclosed experiencing physical abuse from Stefan and that he was having thoughts that she was planning to have him killed (see V above)

VIII. Stefan had been experiencing pain in his hip for some time and reported this to the GP practice in November 2012. X-rays carried out in December 2012 and January 2013 showed a destructive lesion and the strong possibility that this was an indication of cancer.

IX. Stefan did not speak English very well and throughout his relationship with Kara, she had interpreted for him, sometimes for medical appointments. The family and friends state that Kara was asked by GP1 if she could accompany Stefan to the

surgery to discuss the results of the X-ray and at this appointment the seriousness of the result was explained to Stefan. He was informed that further tests would be needed.

X. On the day after this GP appointment Stefan purchased two petrol cans and petrol.

XI. In the early hours of 22nd January 2013 the Police and Fire Service were called by neighbours to the homes of Kara and Stefan because of a fire. Upon entry to the house the body of Kara was found in the downstairs kitchen with head injuries consistent with blunt force trauma and her throat was cut. She had been covered with a petrol soaked blanket and towel. The smoke alarms had been disabled and the gas connections turned on. Petrol had been poured around the upstairs flat and a fire started. The badly burned body of Stefan was found in the upstairs flat.

XII. Stefan had left a number of items outside the house and a note inside the house and while these are not very coherent they reveal that he believed he had cancer and the doctors would kill him. In one of these notes Stefan writes that he had mentioned his concern that there was a plot to kill him to his solicitor in November 2008.

2.3 The national and local context of service involvement

The purpose of this section is to provide the service context in which the homicide occurred and to indicate any changes to that service provision that have occurred within the time frame of this review. It will provide an understanding of any specific factors that impacted on the way practitioners were working during the time period covered by the review and will provide a reference point in which to consider actions to be taken.

2.3.1 Relevant national context

I. The new government definition of domestic violence and abuse was implemented in March 2013 and states:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

II. This can encompass but is not limited to the following types of abuse:
- psychological
- physical
- sexual
- financial
- emotional

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

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

V. The guiding principles in the Government's strategic vision as set out in the *Call to End Violence Against Women and Girls*[2] are to:

- Prevent violence from happening in the first place by challenging the attitudes and behaviours which foster it and intervening early where possible to prevent it
- Provide adequate levels of support where violence does occur
- Work in partnership to obtain the best outcome for victims and their families
- Take action to reduce the risk to women and girls who are victims of these crimes and ensure that perpetrators are brought to justice

VI. Of particular relevance for this DHR is the commitment *to intervene as early as possible* and *to take action to reduce risk to women and girls who are victims of these crimes.*

VII. The last significant UK prevalence study of elder abuse was published in 2007, undertaken by the National Centre for Social Research and Kings College London[3]. This found a prevalence rate of 2.6%, which is equivalent to about one in 40 of the older population. This is about 227,000 people in the UK and is in line with international comparisons. The most likely perpetrator of abuse in this age group (51%) is a partner or spouse.

VIII. In March 2010 the Royal College of General Practitioners launched guidance for General Practices[4] in responding to domestic violence, supported by an e-learning package. This guidance asks General Practices to have established referral pathways for patients who are at risk from domestic violence or who are perpetrating such abuse. This guidance has been an important step in recognising the role that General Practices have as a source of help for many people affected by domestic violence.

2.3.2 Domestic and gender-based violence responses in Barnet relevant to this DHR

I. In the year 2011-12 there were 3.41 domestic violence related offences per 1000 population.

II. There is a relatively high proportion of over 65 year olds at 13.3%, or 47,400[5]. This is numerically the second highest in London, just behind Bromley at 52,000, or 16.6% of the population.

III. Barnet is currently writing its new Violence Against Women and Girls Strategy, the author has seen a draft of this document. The current service provision in Barnet is:

[2] http://www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls/vawg-action-plan?view=Binary

[3] http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076197

[4] http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx

[5] http://data.london.gov.uk/datastorefiles/documents/2011-census-first-results.pdf

- Multi-Agency Risk Assessment Conference[6] (MARAC), the process where professionals meet to share information and develop strategies to reduce risk to victims of domestic violence, with a focus on those deemed to be at most risk. The Barnet MARAC meets every three weeks and has a lower than average threshold for referral. Alongside the MARAC, there is a comprehensive training programme to inform local professionals about how MARAC works. 163 cases were heard at MARAC in 2011-12.

- Solace Women's Aid were commissioned in April 2011 to provide domestic violence services for the borough including:
  - Two refuges, one of which is Jewish Women's Aid with a total of 18 bed spaces
  - An Independent Domestic Violence Advocacy (IDVA) service which includes an IDVA for the Specialist Domestic Violence Court, alongside Barnet Asian Women's Association
  - A perpetrator service delivered by the Respect Accredited DVIP service

- Barnet Children's Services have three specialist domestic violence workers, providing a response to families affected by domestic violence where children are deemed to be vulnerable or at high risk

IV. Support for older residents can be accessed through Barnet Age UK[7] and Barnet Adult Social Care[8] with Barnet Social Direct being the first port of call for people accessing support from Adult Social Care.

V. There is a multi-agency training programme covering domestic violence awareness, risk assessment and referring to MARAC.

VI. There are two organisations in North London providing support specifically for Greek Cypriot Women. In Barnet there is an organisation who provide social and cultural events for the community.

2.4 Analysis of individual management reviews (IMRs)

I. This section of the report provides an analysis of services' involvement and responses to Kara and Stefan, what decisions were made and why, what actions were taken or not taken and how, and if, services were providing help-seeking opportunities. The issues or concerns identified are based on the evidence supplied to the review, or through follow up interviews and information requests.

II. The IMR writers were asked to look in detail at events in the twelve month period before the deaths of Kara and Stefan and to include any events outside this period if relevant to the review.

III. The IMR and the DHR authors have attempted to provide an analysis of the information obtained and to cross reference where possible to increase the confidence in the findings. The DHR author would like to thank all the agencies that provided frank accounts of their involvement and acknowledges the

[6] http://www.caada.org.uk/marac/MARAC_videos.html
[7] http://www.ageuk.org.uk/barnet/
[8] http://www.barnet.gov.uk/homepage/45/

willingness of almost all agencies to engage with the process of the review in order to learn lessons.

IV. In order to focus on the process of each agency's involvement with Kara and Stefan, the report will describe the involvement of each agency separately. All agencies were asked to examine in detail their contact with Kara and Stefan in the year prior to their deaths but to include information relevant to the work of the review that fell outside of this time period. The accounts of agencies' involvement with Kara and Stefan cover different time periods prior to their deaths and some accounts have more significance than others.

V. In the initial stages of the review, there was little indication that any agencies had knowledge of the risk posed to Kara by Stefan, or indeed any involvement with either of them. From the information supplied and the willingness of agencies to engage with the work of the Review Panel, a number of ways to improve service provision have been identified. These are, of course, with the benefit of hindsight, but are also a testament to the value of the DHR process.

2.4.1 Information from family and friends

i. The DHR author met with and maintained contact with Kara's Daughter throughout the review and interviewed four friends of Kara and Stefan. A niece of Kara attended one Panel meeting on the 14th of October 2013. Where appropriate, information from these meetings is referenced in the analysis of the IMRs.

ii. The author would like to thank the friends and family who contributed to the review and this was vital to developing a clear picture of the lives of Kara and Stefan and has helped significantly in the development of the report's recommendations.

2.4.2 Environment and Place Service London Borough of Barnet (LBB)

I. An IMR from Environment and Place LBB was asked for in order to explore whether Kara and Stefan had applied for planning permission to split the house into two flats and whether this provided any information as to the relationship between Kara and Stefan.

II. A planning application for an extension to the kitchen area of the home was granted in 1997. In April 2011 Stefan informed Street Naming and Numbering and Building Control LBB that he was living separately to Kara and, that he resided in the first floor, stating that the property remained the same. It was noted by Street Naming and Numbering, LBB that Stefan and Kara's house had two door bells, 'Mr' and 'Mrs', "so still in single family occupancy so has not been converted".

III. No further checks where undertaken as to the extent in which the house was divided.

IV. The flats of Kara and Stefan received separate council tax bills and were listed as ground floor and first floor flats for council tax purposes from February 2010.

V. There were no recommendations in the IMR report for LBB, Environment and Place.

Analysis and conclusions

VI. The research evidence is clear that separation of a relationship is a time of increased risk for domestic violence, particularly where a separation is contested. The review panel discussed at length when and by whom (and with what remit and training) should questions be asked about the background to a separation and this is an issue that this report will explore further in section 2.4.4 and 2.4.5 and in section three. Given the nature and scope of the contact between Stefan and Kara, it is the Panel's view that there were no missed opportunities to identify domestic violence by the LBB Environment and Place Service.

VII. The two flats for Kara and Stefan had separate door bells and council tax bills and, as supported by statements from friends and family of Kara and Stefan, they were largely living independent lives.

2.4.3 London Ambulance Service

I. The London Ambulance Service have one record in relation to Kara and Stefan, from the morning of 22nd January 2013 when they received two 999 calls (at 6.08am and 6.16am) to their Emergency Operations Centre. These were reports from a neighbour that the home of Kara and Stefan was on fire and that people were inside. A fast response unit and an ambulance were despatched arriving at the address at 06.32am.

II. The body of Kara was found in the rear kitchen area and recognition of life extinct was recorded at 11.55am

III. The body of Stefan was found on the first floor lying flat with total body burns and recognition of life extinct recorded at 12.00pm

IV. The London Ambulance Service was satisfied that all call management and care provided by the attending ambulance staff was in accordance with expected practice.

V. The IMR writer did not include any recommendation for London Ambulance Service

Analysis and conclusion

VI. The Panel had no further comments to the IMR for the London Ambulance Service.

2.4.4 London Fire Brigade

I. The London Fire Brigade's (LFB) first contact in relation to Kara was from Barnet Social Services on 3rd December 2012. This was to request a Home Fire Safety Visit. This was done under the partnership agreement between Barnet Social Services and LFB, whereby identified vulnerable adults or families can receive a Home Fire Safety Visit. Kara was referred as standard practice following a functional assessment on 16th November 2012 by an occupational therapist.

II. The Fire Safety Home Visit was booked via Kara's daughter on 4th December 2012 and took place on 10th December 2012. The LFB staff undertaking the visit found the house divided into two self-contained flats, accessed by a common front door into a hallway with access to the ground and first floor flat. During the visit advice was given to Kara regarding fire safety and two smoke alarms were fitted.

III. No additional vulnerability issues were identity by the LFB staff undertaking the Home Fire Safety Visit nor was there any follow-up report, or recommendation, to Barnet Social Services.

IV. The LFB staff who attended the fire on the 22nd January 2013, while from the same watch, were not the same staff who undertook the visit on 10th December 2012.

Analysis and conclusions

V. The Barnet Borough LFB staff have a minimum of two 3-hour training sessions aimed at skilling up staff on welfare and vulnerability concerns, which is beyond that adopted by other boroughs. The Panel valued the joint working arrangement between Barnet Social Services and LFB and the additional safety this provides for vulnerable adults and families in the Borough.

VI. Given the limited information the LFB would have received from Barnet Social Services and the focus of Home Fire Safety Visits, the panel's view was that there were no missed opportunities to identify domestic violence or other risks to Kara.

2.4.5 Adults and Communities LBB (known during this period as Adult Social Care and Health)

I. The IMR from Adults and Communities covers requests for occupational therapy support for Kara because of the limited mobility she was experiencing prior to a knee replacement operation on 22nd November 2012, a request for a community care assessment following her knee operation and the delivery of this support by Housing 21.

II. The first contact with Adults and Communities was on 22nd March 2012. This was from the AB Women's Association, who had requested information and advice as Kara was having difficulties getting in and out of the bath. A self-assessment form was sent to Kara but there is no record of this being returned.

III. In June 2012 Kara's daughter contacted the service following a fall by her mother in her bathroom. This resulted in an occupational therapy (OT) screening assessment on the phone. This screening assessment noted that Kara lived

alone and she was put on a waiting list for an OT functional assessment. Information on the Assist Lifeline[9] was also posted to Kara.

IV. On 29th October 2012, occupational therapy received a letter from Kara's GP (GP1) requesting an assessment of what her support needs would be after discharge from hospital following her forthcoming knee operation. The daughter of Kara had also written to GP1 to express her frustration at the "lack of progress" by occupational therapy, and this letter was included with that of GP1.

V. On 5th November 2012, following a review of the referral, Kara is contacted by Social Care Direct (the front door service for adult social care) to ascertain the date of her knee operation, stating her needs would be assessed by the hospital occupational therapists prior to her discharge.

VI. Kara's referral is allocated to an Occupational Therapist for a home assessment visit on 14th November 2012 and the assessment took place on 16th November 2012 at Kara's ground floor flat.

VII. The Occupational Therapist noted that Kara lived alone, that her next of kin was her daughter and that Kara was alert. In a subsequent phone interview with the report author, the Occupational Therapist reports that the assessment had explored the support Kara had available to her, her emotional and psychological wellbeing, as well as her physical mobility. During the assessment no mention was made of Stefan or that he lived upstairs.

VIII. As the Occupational Therapist was leaving Kara's flat they talked to Kara about possible additions that could be made to the entrance to the building to make access easier. At this point Kara mentioned that she would need to consult with her husband who lived upstairs before making additions to the front of the house. The Occupational Therapist's notes state that the house is split into two flats and Kara's husband lives upstairs.

IX. Following the Occupational Therapist's visit a range of actions were agreed, which were outlined in a support plan and sent to Kara and the Home Fire Safety Visit was requested (see 2.4.4.).

X. Kara's daughter contacted the occupational therapy service on 30th November 2012 to inform them that Kara was discharged from hospital on 28th November 2012 and OT ordered the equipment to support Kara's ability to manage independently within her home.

XI. Kara's daughter had been providing care and support for her mother following her hospital discharge. On the 3rd December 2012 she informed Barnet Social Care Direct that she would be returning home soon and that her mother would need additional support at home. On 4th December 2012 a phone assessment of Kara's needs took place.

XII. The phone assessment by Social Care Direct on 4th December 2012 was wide ranging, covering daily activities, psychological well-being, housing and any risk of harm, including abuse by others and her feelings of safety in her home. Kara is recorded as answering no to questions about whether she was experiencing abuse or at risk from others. The worker undertaking the assessment remembers her responding with "no problems like that".

[9] http://www.barnet.gov.uk/info/313/alarm_services/392/alarm_services

XIII. The OT equipment and adaptions were due to be installed on 7th December 2012 and an eight week home care package was put in place starting on 10th December 2012.

XIV. Housing 21 were the suppliers of the care package. A senior carer from Housing 21 visited Kara on 11th December 2012 and was informed by Kara that she would like the care to start on 17th December 2012 as her daughter was staying for longer. Also, on 11th December 2012 occupational therapy called Kara to follow up on the equipment, which had been partly installed but not all delivered.

XV. Kara contacted Social Care Direct on 7th January 2013 to inform them that she no longer needed the care package as she had regained her mobility. She enquired about the Lifeline service and the worker sent her an application form.

XVI. The short term enablement team received an update from Housing 21 on 16th January 2013. This detailed Kara's improved mobility and psychological well-being and stated that no other risks were identified.

Analysis and conclusions

The purpose of the DHR is not to comment on the overall Social Care response but to ascertain if opportunities were missed to identify risks to Kara from Stefan. The points of opportunity to identify, highlight or explore risk to Kara from Stefan are:

1. GP1's letter received by OT 29th October 2012 asking for an assessment
2. Occupational Therapist's home visit on 16th November 2012
3. Social Care Direct phone assessment 4th December 2012
4. Housing 21's initial assessment of the care package 11th December 2012

- GP1's letter to OT asking for an assessment 29th October 2012

GP1 did not raise any concerns about the risk posed by Stefan. The risk was not identified by GP1 and a longer discussion of this takes place in section 2.4.9.

- Occupational Therapist's home visit on 16th November 2012

Kara presented herself as living alone. The Occupational Therapist was unaware that Kara was married to Stefan and that he lived in the flat upstairs, until she was leaving Kara's home. Kara had given her next of kin as her daughter and had not mentioned Stefan during the assessment. However, when the Occupational Therapist became aware that Kara's husband lived upstairs some discussion could have taken place as to the nature of their relationship and if her husband was a source of support for Kara. An opportunity to explore the relationship between Kara and Stefan was missed at this point.

The information that Kara's husband lived upstairs came to light at the end of the interview, as the Occupational Therapist was leaving and concluding their assessment. This was not explored at this point, nor was it picked up at any subsequent point.

The living arrangements of Kara and Stefan were unusual. For a couple to separate particularly because of abusive behaviour, but remain living in the same house, albeit in separate flats, is an uncommon living arrangement. Separation, particularly where

this separation is contested, can frequently increase risk to victims of domestic violence[10]. This warranted further exploration and was not identified at this or subsequent points. The Occupational Therapist was performing their role as expected and heard about Stefan's existence at the very end of the interview. However, the significance of having a separated husband living in the same building was not explored. There is no assumption that this would have revealed any of the risks posed by Stefan, but the opportunity to enquire further about this relationship was missed.

During a follow up interview with the OT who undertook the assessment on 16th November 2012 they were asked about their training on safeguarding and domestic violence. The report author was informed that this is regularly updated and had been in recent weeks, covering domestic violence and abuse to older people.

- Social Care Direct, Phone Assessment on 4th December 2012

The Social Care Direct Assessment as discussed above was detailed and did ask about risks from family and carers. The Panel's view is that there was not a missed opportunity to explore risks to Kara. However, it is noted that no questions were asked about the unusual living arrangement and Stefan's interaction with Kara.

- Housing 21's initial assessment of the care package, 11th December 2012

The IMR from Housing 21 is discussed in section 2.4.6. Housing 21 were unaware that Stefan was living upstairs from Kara and this was not included in the information given to Housing 21 (see 2.4.6 below).

There appear to be two missed opportunities to have explored the relationship between Kara and Stefan, one at the point where Kara informed the Occupational Therapist that Stefan lived upstairs and the second when questions about this relationship were not asked in the rapid assessment by Social Care Direct.

2.4.6 Housing 21

I. Housing 21 are a provider of care for the older population and were contracted by Barnet Council to provide the additional care after Kara's knee operation. Kara was referred to Housing 21 on 4th December 2012 for a service that was to run from 10th December 2012 to 4th February 2013. The plan required Housing 21 to assist Kara twice a day, seven days a week, for eight weeks. It was expected that Kara would be fully independent at the end of the period.

II. An initial assessment by a Housing 21 senior carer was undertaken on 10th December 2012. This took place at Kara's home and her daughter was present. During this visit, while the senior carer was talking to Kara's daughter, Stefan came down from his flat and spoke to Kara. The daughter told Stefan to leave and said to the Housing 21 employee that he was Kara's husband and that she could not stand him. The senior carer said that that this was not a heated exchange and at no time was she aware of any concern with regard to Stefan.

[10] Hoyle, C (2008) Will she be safe? A critical analysis of risk assessment in domestic violence cases. In Children and Youth Services Review 30 (2008) 323 - 337

III. The care package started on 17th December 2012 at the request of Kara and was ended by Kara on 8th January 2013. The last visit to Kara by Housing 21 was 7th January 2013. During this period a number of visits were cancelled by Kara, as she had stated that these were not required.

IV. The carers who attended Kara have been asked about their recollections of her. In the short time that Housing 21 were supporting Kara, there were a number of carers, who would each be seeing around forty individuals each per week. There was no regular carer with specific responsibility for Kara. None of the carers remember any other person being there during their visits and they state that Kara was co-operative and did not come across as worried or concerned.

Analysis and conclusions

V. The response provided by Housing 21 is guided by three things, the information they are provided with by LBB Social Care Direct, their assessment of the needs and risks in relation to Kara and Kara's wishes.

VI. In this case no concerns were flagged in the referral to Housing 21 (see section 2.4.5). The report author had a phone interview with a Housing 21 manager, following up on their IMR. In this interview the Housing 21 manager stated that if concerns had been flagged they would have allocated one regular carer to monitor Kara closely.

VII. In the author's phone interview with a Housing 21 manager, they stated that it is not unusual for there to be other family members around in the home of the person they are providing care for who do not have a direct role in caring for that person themselves. Therefore, when Stefan appeared in Kara's flat during their initial assessment this would not prompt Housing 21 to flag this with the LBB Social Worker.

VIII. While a care package like this is being delivered, a carer's communication log is kept at the home and updated by each carer. It is the mechanism by which one carer can communicate information to the carer undertaking the next visit. Housing 21 were unable to retrieve this from the address after the fire, nor is this in the possession of the police or Kara's daughter. Kara's daughter stated that she had never seen this and that her mother would have been unlikely to have kept this item.

2.4.7 Barnet and Chase Farm Hospital (BCFH) NHS Trust

In relation to Stefan

I. Stefan's involvement with BCFH largely consisted of a series of appointments with ophthalmogy in 2009/10 to address a cataract and drooping eye. There are no other records of Stefan until 17th January 2013. Where a referral letter is received for a possible pathological hip fracture and an appointment is given for two weeks from that date.

II. Stefan did attend Finchley Memorial Radiology on 17th December 2012 for a lumbar x-ray and on 11th January 2013 for a hip x-ray, the results of which were faxed to the GP on 17th January 2013, prompting the referral letter above.

In relation to Kara

III. Kara had a series of appointments at BCFH during 2010-12 for treatment for either a thyroid or a knee problem.

IV. However, on 6th August 2012 Kara attended Accident and Emergency with swelling to right side of her face and throat and was seen by a consultant and given an x-ray. Kara stated that she had woken up with bruising to her right eye but denied that this was the result of an injury. She was seen for a follow up appointment and low ferritin levels were noted. The Family General Practice (FPG) was informed of this attendance.

Analysis and conclusions

V. The main area of interest for the DHR is the attendance on 6th August 2012 with bruising to the face and swelling of the throat. Kara's explanation for this was that it was spontaneous, that she woke up with this injury. The consultant's view is that this was not plausible as it would be difficult to explain the injury other than blunt trauma to the area.

VI. When Kara was asked specifically if the bruising to the face was the result of injury, she denied this, as she had earlier (see 2.4.8). The consultant did reflect, in conversation with the IMR writer, as to whether there was a willingness to accept Kara's explanation for the injury because of her age, and the view that it is more common for older patients to injure themselves. Kara's GP was informed and there was the possibility for further follow up from GP1.

VII. The Panel's view was that domestic violence training at BCFH should be reviewed and that the safeguarding training that is currently on offer did not cover domestic violence sufficiently and should be reviewed.

2.4.8 Central London Community Health Care (CLCH) - Walk in Centre (WIC)

In relation to Stefan

I. Stefan was seen on seven occasions between 2006 and 2009; on five occasions for physiotherapy, once for a chest infection and once for dental treatment. None of these contacts had relevance for the work of this DHR.

In relation to Kara

II. Kara was seen on ten occasions between 28th February 2007 and 5th December 2012; twice for podiatry appointments, on five occasions at the Walk-in Centre (WIC) and twice by the District Nurse in relation to her knee operation. One of the visits to the WIC on 6th August 2012 is of relevance for this DHR.

III. On 6th August 2012 Kara presented at WIC with bruising and swelling to the right side of her face. The cause of this bruising was not identified. Kara was asked if the bruising was the result of an injury by both the WIC doctor and nurse, but she denied that she had received any injury to her face. The WIC centre referred Kara to Accident and Emergency for blood clotting screening (see 2.4.7). A report of this attendance was faxed to the Family General Practice.

Analysis and conclusions

IV. Kara and Stefan had little contact with CLCH services. On 6th August 2012 staff at the WIC noted the possibility that Kara's bruising could have been the result of an injury and she was asked about this on two occasions. On both occasions she denied that this was the case, as she did later when she presented at Barnet and Chase Farm Hospital.

V. All staff at CLCH received safeguarding adults training with a mandatory update every three years. Domestic violence is discussed as part of this training. The IMR writer notes that this training could be further strengthened, however this was not an issue in the response to Kara.

2.4.9 Family General Practice (FGP) (General Practice for both adults)

I. The DHR panel would like to note the excellent work done by the IMR writer in producing this IMR and the addendum information. Kara and Stefan registered with FGP on 6th June 1997. The IMR writer looked at all the records available and interviewed the GP registrar, the nurse practitioner and GP1 who saw Kara and Stefan most frequently, to all intents and purposes their GP. The Panel requested that the archived paper records also be retrieved, specifically to check if they would further illuminate the nature of the relationship between Kara and Stefan and whether there was any history of domestic violence. A full chronology for the 12 months prior to the homicide was provided and the IMR included other information from the medical records relevant to the work of the DHR.

II. The archived paper records cover a period from 1962 – 2002. Kara and Stefan registered with the FGP on 6th June 1997. Therefore the paper records included entries from other practices as well as those from the FGP.

III. Information from the archived paper records included a record from 18th July 2002 which is a letter from the Royal National Throat, Nose and Ear Hospital to the FGP, thanking them for referring Stefan, who was seen with Kara who interpreted for him.

IV. The first recorded violence from Stefan to Kara is 9th April 1987 when a GP, at a previous practice, records "hit by husband 4 days ago. Bruise to lower lip…area of the scalp ….pulled hair, pulled patient while driving…… Bruising to larynx and difficulty talking. Seen solicitor this AM."

V. There is another record of violence by Stefan to Kara later the same year, which notes "kicked by husband", again this is from a GP at a previous practice.

The electronic FGP record entries in relation to Stefan

VI. Over the year prior to the homicide, the FGP records show that Stefan was seen for routine appointments monitoring his blood pressure until 21th November 2012, when he complained about pain in his thigh and restricted movement of the hip. He was seen by GP1 on 17th December 2012 and attended radiology the same day and then again on 11th January 2013. It is from this appointment that a "destructive lesion" is identified, which requires urgent attention and which may be cancer.

VII. On 16th January 2013 the consultant radiologist faxed over a report to the FGP. There is a record from GP1 on 16thJanuary 2013 which states that "separated wife lives downstairs but still cares about general well-being – will accompany him (Stefan) tomorrow"

VIII. GP1 contacted Kara on 16th January 2013 and she accompanied Stefan to the surgery the following day for an appointment with the GP registrar. Kara had a landline at her flat and Stefan had a mobile phone. GP1 states that Kara's landline number was the only contact number in Stefan's notes. It was noted in the SGP records that Stefan's understanding of English was low and he had difficulty understanding information over the phone.

IX. On 17th January 2013 the GP Registrar (GP1 was unavailable) saw Stefan, accompanied by Kara. The notes of this consultation state "Discussed…… with patient (Stefan) and wife results – explained shows lump going into the hip, and maybe cancer…… Patient convinced it is not cancer but understands need for tests to see if other signs of cancer elsewhere."

The electronic GP record entries in relation to Kara

X. There are occasions when Kara visited FGP with some form of physical injury, June 1997 with a bruise to the left arm, February 2004 shoulder and knee pain after a fall, November 2004 bang to back of head and left arm after another fall, August 2009 bruising to her chest. For each of these injures Kara had explanations that were not linked to the behaviour of Stefan.

XI. There are a number of entries in the FGP record that referred to Kara's problems in her relationship with Stefan.

- 6thAugust 2003 "anxiety and depression. Husband doesn't help at home". Discussion - GP

- 9th February 2004 “relationship problems. Shoulder and knee problems after fall” – GP
- 22nd March 2006 “Anxiety and depression trouble with husband….Husband not very thoughtful – does nothing around the house and not working. Not keen on counselling or anti-depressants. Was happy to talk about things with me” GP
- 2nd November 2009 “stress at home problems with husband. Has decided to separate – they will separate the house and she will live downstairs”
- 23rd November 2009 similar to the above with the addition that “she is blaming herself for the problems”

XII. There are no relevant records after the above until 13th January 2011 where the receptionist takes a phone message from the daughter of Kara for GP1 saying “Very worried about her mother because of the actions of stepfather, feels he is being verbally abusive, says her mother has spoken to you before about this – did not want to leave a message with another doctor, happy to wait till Monday….”

XIII. On 17th January 2011 GP1 had a phone discussion with the daughter of Kara and notes “At risk of physical abuse. Discussion with daughter regarding Stefan. Feels his judgement is impaired. Tends to get paranoid. Worried about her mother who lives downstairs. Advised that I will arrange to see her mother.”

XIV. On the 24th January 2011 GP1 saw Kara to follow up on the concerns raised by her daughter. During this consultation Kara explained that she was stressed, that Stefan was having paranoid ideas that she would send a black man to kill him. Kara said that she had pain in her right shoulder from an assault by Stefan about a year earlier and that was the most recent incident. Kara stated that this was because he was not drinking as much, she also stated that she would be seeing a solicitor. The record of this consultation did not come to light until after the IMR and the overview report was submitted to Home Office (2014) and has been included here following a further additional discussion with the DHR Review Panel.

XV. On 6th August 2012 there is record of the faxed patient contact from the Walk-in Centre (see section 2.4.7 and 2.4.8). The record states that Kara “woke up on Saturday with right side facial pain and mild bruising to the face and bruising beneath the right eye appeared on the Sunday. Denies injury to face and eye”

XVI. There is a consultation with the Nurse Practitioner on 20th August 2012 which notes Kara “feels unwell since episode of spontaneous bruising over the right eye, has affected throat and neck. Headaches, feels can’t breathe at night”.

XVII. There are no other records in Kara’s file after the 20th August 2012 that are of relevance for the work of the DHR.

Analysis and conclusions

XVIII. GP1 would have been unlikely to have read the archive hand written records. These state clearly that Kara had experienced domestic violence from her husband, Stefan. If they had been read or more realistically if this was flagged up

on the medical records, then injuries and discussions “of stress at home” and “trouble with husband” could have been viewed within a context of on-going domestic violence and abuse.

XIX. The GP1 and the Nurse Practitioner both say that Kara complained that her husband had affairs, that he drank a lot and that he hardly did anything around the house. However, both report that Kara did not state that she was experiencing physical abuse from Stefan. GP1 told the IMR writer that Kara would describe her husband as “an evil man”. The GP1 states she asked what Kara meant by this and she was told that Stefan drank a lot and went with other women. These statements could have prompted a more direct exploration as to whether Kara was in fear of Stefan or experiencing physical abuse from him.

XX. Kara’s daughter states that she attended an appointment with her mother and GP1 in 2009, where she raised concerns about her mother’s well-being and her step father’s behaviour. However, the IMR found no record of this and found the records at the practice to be comprehensive and thorough. The DHR panel noted the difference between the FGP records and Kara’s daughter’s statement but was unable to resolve this.

XXI. Following the call from Kara’s Daughter on 17th January 2011 in which she raised concerns about the risk to Kara and about Stefan’s mental health and the follow up appointment where these concerns where confirmed there were missed opportunities to intervene. When GP1 is informed of the bruising to Kara’s face in August 2012 another opportunity is missed to explore risk.

XXII. GP1 reflected that following the phone conversation with Kara’s daughter and Kara’s disclosures there was the opportunity to have made a referral to a domestic violence agency. GP1, like many GPs, had no training on domestic violence and stated to the IMR author that they would not have known who to make the referral to. The practice did not have information that was visible in the waiting area on domestic violence or information for patients to take away.

XXIII. Friends of Kara and Stefan have reported that Stefan was “obsessed about the house” and had changed his Will so that Kara or her daughter would not inherit half of the house. He had stated to friends on different occasions that he believed that Kara, her brother (now deceased) and daughter were plotting to have him murdered. That he had overheard them saying they were going to “pay a black man £10,000 to have him killed”. GP1 states that Stefan’s behaviour and presentation at the GP Practice had not given her concern about his mental health.

XXIV. The daughter and a friend of Kara who both had contact with Kara after she had been informed about Stefan’s X-ray results have stated that Kara was very distressed about acting, as Kara understood it, as interpreter and support for Stefan. She did not want to do this but felt she had little alternative. Kara had undertaken this role for some considerable time and is first noted acting as interpreter in the GP records in June 2002. Taking into account the seriousness of the information that needed to be imparted to Stefan, the documented problems that Stefan’s behaviour had caused Kara, his paranoid thoughts, their separation and his violence towards Kara, the choice by the GP Practice to ask Kara to accompany Stefan to this medical appointment, is in the Panel’s view questionable.

XXV. Kara contacted her daughter the night before attending the FGP surgery and discussed with her daughter how distressed she felt at having to attend this appointment and that she did not want to be in this position. This conversation was witnessed by a friend of Kara's daughter.

XXVI. There was no record of Stefan having requested Kara to be at these appointments. While it is understandable that GP1 would want to ensure that someone who was going to get grave information about their health had some support, there does not appear to have been sufficient consideration or exploration of the nature of the relationship between Kara and Stefan before including Kara in this consultation.

XXVII. The panel was unable to find guidance for GPs on the inclusion of family members in this type of consultation, particularly where they are interpreting.

XXVIII. Kara had acted as interpreter/support for Stefan in the past and given the seriousness of information about Stefan's health, she may have found it difficult to withdraw from this role. Kara had made it clear to her daughter and a friend that she no longer wanted to be in this position. Kara said to her daughter, and on another occasion to a friend, that she felt she did not have another option other than to accompany Stefan. Kara was placed back in a position where she was responsible for supporting Stefan and feeling that she was acting as an interpreter/support for him, a situation that she had previously removed herself from, by separating from him. While there is no evidence that these concerns were voiced to GP1 by Kara, there is also no evidence that the impact of attending the FGP to support Stefan was explored with Kara.

XXIX. There is very little guidance for GPs (or other health care staff) on the use of interpreters or when it is, or when it is not, appropriate to ask a family member to interpret for another during a medical consultation. This lack of guidance appears to be a significant gap, leaving GPs and others to use their judgement on a case by case basis. While the use of judgement needs to be part of any decision-making process, the lack of guidance could leave some people vulnerable and medical professionals without an appropriate framework in which to make these judgements.

XXX. It is the Panel's view that more could have been done to consider the needs of Kara and the possible risk to her before involving her in the consultations on Stefan's health.

XXXI. The concerns raised by Kara's daughter and Kara about the mental health of Stefan were not explored. There are statements from Kara, her daughter and a friend of both Kara and Stefan that he was susceptible to delusions that Kara was plotting to have him killed.

XXXII. In the notes left by Stefan after killing Kara and himself he writes about a plot to kill him and that he had mentioned this to his solicitor. In these notes he also states that doctors are going to kill him.

XXXIII. Since the start of the DHR process the Family General Practice has sought training on domestic violence and their prompt action in this regard is recognised.

2.4.10 AB Women's Association

I. Women's Association's contact with Kara was not the subject of an IMR, they contributed to the work of the Review through two interviews with the report author; one in person with the member of staff who had undertaken case work with Kara and one by phone with the Service Manager.

II. Kara had contact with the Women's Association over a number years starting in 2006 when she attended English classes. She continued to have contact with the service through to 2010, attending an oral history group and seeking specific help in relation to welfare benefits following her separation from Stefan.

III. Kara would often attend the Women's Association with one of her close friends and access social support as well as specific advice.

IV. Kara asked the Women's Association for advice on her pension and benefits and was given a case worker on 26th April 2010. She was concerned about the implications of Stefan changing his Will and the ownership of the house to tenants in common. She was seen on a number of occasions by a case worker and they resolved Kara's concerns about her benefits and she was advised to see a solicitor. The Women's Association suggested that Kara seek advice from L and Co, Solicitors, which she did (see 2.4.11).

V. After Kara stopped attending the service they maintained occasional phone contact to check on her well-being.

VI. During her time at the Women's Association Kara spoke of her unhappiness in her relationship with Stefan, that he made it difficult for her to have contact with them, he did not like her attending or her being away from him. She said that her husband would shout at her and that she was scared of him shouting at her. Kara did not disclose to the Women's Association that she was experiencing physical violence.

VII. The AB Women's Association stated that Kara was offered counselling about the relationship but she declined this.

Analysis and conclusions

VIII. AB Women's Association is one of the few agencies, outside of her FGP, that Kara approached for support. The fact that this is a Greek Cypriot Women's Service, and recommended by a friend, no doubt contributed to this service appearing approachable. This report will discuss this further in the lessons learnt section below.

IX. AB Women's Association reports that they have a number of women approaching the service who disclose domestic violence, but they do not have staff with domestic violence expertise. Sometimes they are able to offer counselling, although this limited, and they also make referrals to other agencies. The referral to a solicitor was a referral that met some of the needs expressed by Kara.

X. If the service had a domestic violence specialist, or a more established relationship with one or more of the domestic violence specialist services, this could have been offered to Kara and would have been appropriate.

2.4.11 L and Co solicitors

I. L and Co solicitors contributed to the review through a phone interview with the report author on 17th April 2013. This confirmed that Kara had one consultation with a solicitor at L and Co in the later part of 2010 where she had asked about the process of seeking a divorce and the implications of this for her.

II. Following the above consultation Kara instructed the solicitor to prepare her Will which was executed on the 26th January 2011.

III. The solicitor at L and Co who saw Kara stated that at no point did she disclose that she was experiencing abuse from Stefan and that she had stated that her reason for discussing a divorce was that she was not happy in the relationship. Following the consultation there was no instruction from Kara for further action.

Analysis and conclusion

IV. The contact between L and Co and Kara was brief and in the Panel's view there was no missed opportunity to identify risks to Kara.

Section Three: Lessons learned

This section of the report will address the specific questions in the terms of reference (in the boxes below) and will then draw out themes arising from the review that can inform the implementation of the recommendations. The specific questions from the terms of reference are in the boxes below.

i. Was there evidence of a risk of serious harm to the victim that was not recognised or identified by the agencies in contact with the victim and/or the perpetrator, it was not shared with others and/or it was not acted upon in accordance with their recognised best professional practice?

There is evidence that the Family General Practice did not recognise the risks to Kara following the concern's raised by her daughter and confirmed in an appointment with Kara on the 24th January 2011.

ii. Where any of the agencies or professionals involved consider that their concerns were not taken sufficiently seriously or not acted on appropriately by the other parties involved?

No agencies or professionals expressed concerns about the risk to Kara or the risk posed by Stefan.

iii. Did the homicide indicate that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency?

No professional raised concerns and there is no evidence that local procedures were not followed.

iv. Whether the homicide appears to have implications/reputational issues for a range of agencies and professionals?

The lack of training and support for Primary Care in recognising and responding to domestic violence leaves General Practices in particular, under-prepared to respond to the needs of patients who are experiencing or perpetrating domestic violence.

v. Does the homicide suggest that national or local procedures or protocols may need to change or are not adequately understood or followed?

That Adults and Communities change procedures to ensure when undertaking enablement assessments and the subject states they are separated from their ex-partner, that the nature of that relationship and any current risks, specifically domestic violence, are explored.

The current guidance from the Royal College of General Practitioners on responding to domestic abuse[11] is not widely understood, nor is there a mechanism to ensure that it is taken up. This DHR makes recommendations for NHS England and the local Clinical Commissioning Group to ensure that this is addressed.

Vi The victim had no known contact with any agencies. For example, could more be done in the local area or within specific communities to raise awareness of services available to victims or perpetrators of domestic violence?

Services for specific sections of the community, in this case AB Women's Association, often provide a service to more than one Local Authority. In this case Barnet residents accessed a service in a neighbouring Authority as the same service is not available in Barnet. Where this happens, London Councils should continue to ensure that effective referral pathways exist into local domestic violence services when people access services out of borough. This would require ensuring that organisations are appropriately funded to undertake this pan borough remit.

More could be done to increase awareness that domestic violence affects older people and for specialist services to present themselves in a way that makes them attractive to this age group. Alternatively, for specialist domestic violence services to create access points into their service within other services that older members of the community already use. During the course of the DHR Solace Women's Aid obtained funding for the "Silver Project" which aims to address these concerns.

The review highlighted two areas that would benefit from being addressed at national level:

1. The review noted an absence of guidance for GPs and other health care staff on the use of interpreters and specifically under what circumstances a family member should be acting as an interpreter. The Review Panel noted this is a very significant gap.

2. The IRIS[12] initiative which supports GP practices in identifying and responding to domestic violence would benefit from rollout across England, rather than being left to individual Clinical Commissioning Groups to pursue. Not rolling IRIS out nationally would continue to lead to inconsistent responses and the message that responding to domestic violence is an optional rather than a core responsibility.

Specific lessons

Younger women (16-24) are more at risk of domestic violence than older women,[13] so it is unsurprising that there is a focus on this age group. There are significant numbers of children subject to a social work intervention due to their exposure to domestic violence. Barnet has 3 specialist domestic violence social workers supporting families affected by domestic violence. Alongside this, the age at which someone can be recorded as a victim of domestic violence has decreased from 18 to 16 in the Government definition of domestic violence, with an increasing public

[11] http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Domestic%20Violence/RCGP-Responding%20to%20abuse%20in%20domestic%20violence-January-2013.ashx
[12] http://www.irisdomesticviolence.org.uk/iris/
[13] http://www.ons.gov.uk/ons/dcp171778_298904.pdf Page 70

awareness of domestic violence in teenage age relationships. These are all to be welcomed. However, domestic violence can affect all age groups, as this review highlights, and there are dangers in having a response to domestic violence that looks to the community like it is geared only to the needs of younger people and families.

Improving the reach of local domestic violence services is part of the remit of the Safer Communities Partnership Board and this should be translated into action for older members of the community. There is a lack of visibility of older service users in public education and awareness-raising material for domestic violence services. With an ageing population (Barnet has the second highest population of over 65s in London) more could be done to ensure that the needs of this age group in relation to domestic violence are not overlooked.

Specific issues in relation to the identification of risk

Given the unusual living arrangement, with separated husband and wife sharing the divided house, someone reviewing the care needs of Kara should have enquired as to the relationship between Kara and Stefan. While questions were asked of Kara as to whether she believed she was at risk from abuse, specific questions about her relationship with Stefan were not asked. Women who are separated have a higher risk of domestic abuse compared with all other groups by marital status[14].

This review has a specific recommendation for occupational therapy/adult social care in relation to separated couples.

People experiencing domestic violence often make statements that indicate they may be at risk, as did Kara. However, she did talk about experiencing domestic abuse, about verbal abuse and about feeling scared. The government definition of domestic violence highlights coercive behaviour, defined as an "act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim".

There is tendency to reduce domestic violence down to acts of physical violence and this was evident in some of the statements made by professionals. Kara did disclose abuse and behaviours that would amount to coercive control but this was not always recognised as domestic violence and abuse and it did not prompt a further assessment of risk. There is a need to improve the ability of public-facing services to hear when those experiencing domestic violence are communicating this, to recognise it as abuse and to know that it is their role to sensitively ask more.

There were opportunities for professionals to have asked more, to have explored risk, to have felt confident enough to do this in a sensitive way, knowing that they had something to offer if domestic violence was recognised.

The training for public-facing services should do more than increase awareness, or inform how to refer to MARAC, but needs to equip professionals on how to recognise the need to ask more, what questions to ask and how to make referrals to a specialist agency or involve them, if needed. Being able to recognise when someone might be experiencing domestic violence should be recognised as a core competency.

[14] http://www.ons.gov.uk/ons/dcp171778_298904.pdf Page 71

Section Four: Recommendations

4.1 London Fire Brigade (LFB)

- The partnership work between LFB and Barnet Social Services whereby vulnerable adults and families are referred to the LFB for a Home Fire Safety Check to continue. This recommendation was also put forwarded by the IMR writer.
- The current safeguarding training to remain programmed into the borough training plan, so that all watch members receive training on safeguarding procedures annually. This recommendation was also put forwarded by the IMR writer.

4.2 Barnet Adults and Communities – Occupational Therapy

Occupational therapists have a unique role in supporting the independence of older members of the community as they visit older people in their homes to assess their support needs. Therefore, occupational therapists have first-hand experience of older people's living arrangements and are well placed to identify abuse. In support of this function the panel recommends:

- When an occupational therapist undertakes an enablement assessment where a patient states that they are separated from their partner, this must prompt questions as to the background to the separation, current contact and domestic violence risks. This is especially pertinent if they remain in the same house, even if living separately.

4.3 Capita - Social Care Direct

- Social Care Direct staff are required to explore issues of abuse during their rapid assessment process. Capita and Barnet Adults and Communities should review the training needs for staff undertaking this role and ensure that they are adequately equipped to explore these issues.
- When undertaking an assessment of someone who states that they are separated from their partner this must prompt questions as to the background to the separation, current contact and domestic violence risks.
- The structure of the rapid assessment form used by Social Care Direct to be amended to include specific prompt questions to explore domestic violence. Social Care Direct to liaise with Solace Women's Aid to progress this.

4.4 Housing 21

- To strongly consider introducing a more secure system for the recording of carer notes. The current paper system is prone to loss, as in this case. Improvements in technology, particularly the ability to use mobile devices to access and update central records, should be considered in a review of the current system.
- To ensure that staff providing care have training on domestic violence that covers risk indicators and specifically that separation may not indicate a reduction in risk

4.5 Barnet and Chase Farm Hospital (BCFH) (NHS Trust)

- To review its policy and procedures in relation to domestic violence to ensure that these include routine enquiry for domestic violence where patients present with injuries that are consistent with an assault
- To review its policy and procedure on domestic violence and ensure that this covers concerns about injuries to older people and their barriers to disclosure
- The Trust should develop a good working partnership with Solace Women's Aid to support the training of staff and to ensure that BCFH staff know how to refer to local domestic violence specialists when appropriate.
- The training provided to BCFH staff to be reviewed to ensure that it adequately equips staff with the knowledge and skills to enquire sensitively about domestic violence, including with older patients. This recommendation was also put forwarded by the IMR writer.

4.6 Central London Community Health Care (CLCH) – Walk in Centre (WIC)

- That the Adastra electronic records used in the WIC and elsewhere has a flagging system that covers vulnerable adults.
- That the links between CLCH and partner domestic violence agencies be improved by the attendance at MARAC of the CLCH Safeguarding Adults leads
- That there is specific training on domestic violence for Adult Services staff that covers recognition, routine enquiry and signposting to appropriate services. All the above recommendations were also put forward by the IMR writer.

4.7 Family General Practice

- To develop a policy on the use of interpreters given the current gap in national guidance and to consider under what circumstances it is appropriate to use friends or family members as interpreters.
- To develop a policy on domestic violence that includes a requirement that all staff have training on domestic violence in line with their responsibilities. This should equip staff to be able to recognise when someone may be experiencing domestic violence, to enquire sensitively, recognise risk and refer where appropriate.
- The General Practice to incorporate the Royal College of General Practitioners' (RCGP) guidance on responding to domestic violence into their own policy.
- To ensure that information about domestic violence and sources of help for both victims and perpetrators is visible to patients and available to take away from the practice.

4.8 Barnet Clinical Commissioning Group and NHS England.

These recommendations are directed towards both NHS England and Barnet Clinical Commissioning Group. At the time of writing it was unclear which body would have responsibility for taking them forward.

- To be assured that primary care are adopting the RCGP guidance on domestic violence across all settings.

- To commission the IRIS model to improve the early identification of domestic violence in primary health care.
- In conjunction with the Barnet Safeguarding Adults Board and the Barnet Public Health lead, ensure that materials are available in all primary care settings promoting services for domestic violence victims and perpetrators.
- To ensure that there is adequate guidance available for health care staff on the use of interpreters and specifically when it is not appropriate for a family member to act as an interpreter during medical consultations.
- Consider a "tag and flag" system for medical records of those at risk of domestic violence. Where such notes are archived, to ensure that such tag and flag notifications are transferred along with the notes.

4.9 Barnet Safer Communities Partnership Board

- Barnet has the second highest number of over 65 year olds in London, over 47,000 at the last census[15]. This needs to be reflected in the Barnet DV and VAWG Action Plan so that the particular needs of this section of the community are recognised.
- To consider how best to increase awareness that domestic violence occurs across the age spectrum through the use of public education materials.
- Ensure that the needs of older victims of domestic violence are acknowledged and represented in domestic violence training provided across the borough.
- To take account of the help-seeking pathways that are frequently utilised by older citizens, and those from minority communities, when commissioning domestic violence services.
- Ensure that domestic violence training equips professionals with the skills to recognise when someone may be at risk of experiencing or perpetrating domestic violence, in order to respond and enquire sensitively, recognise risk and refer if appropriate.

4.10 Solace Women's Aid and AB Women's Association

- Solace Women's Aid and AB Women's Association with the support from the Barnet Domestic Violence Co-ordinator to explore a closer working relationship to ensure that women using AB Women's Association have access, when needed, to the domestic violence expertise of Solace.
- Solace Women's Aid to utilise the expertise of AB Women's Association to ensure that their services are accessible and appropriate to Greek Cypriot women.
- To explore how to make the above process as seamless as possible for service users

4.11 National Institute for Clinical Excellence

- To consider guidance for health care staff on the use of interpreters and specifically under what circumstances a family member should and should not be acting as an interpreter.

[15] http://data.london.gov.uk/datastorefiles/documents/2011-census-first-results.pdf

Author of report:	**Neil Blacklock**
Designation and organisation:	**Development Director, Respect**
Date:	**02.12.13**

Appendix One: Chronology of significant events and agency involvement

Date	Event
25 January 1932	Birth of Kara
16 February 1943	Birth of Stefan
4 December 1957	Birth of Kara's daughter
1977	Kara divorces first husband
18 March1977	Kara and Stefan marry
1978-80	Reports from friends of arguments between Kara and Stefan and physical violence from Stefan towards Kara
Mid 1980's	Kara sells her business
9 April 1987	Kara's injuries recorded by GP as the result of an assault by Stefan
21 August 1987	Kara's injuries recorded by GP as the result of an assault by Stefan
1987 -1997	Kara and Stefan move to Greece to set up a business running a bar
1988-89	Daughter of Kara witnessed Stefan hit Kara in the face during a taxi ride while visiting them in Greece
1997	Kara and Stefan return to Barnet after their business fails in Greece
1997	Kara and Stefan register with the Family General Practice
2007-09	Friends and family of Kara and Stefan note that Stefan's behaviour had become more aggressive. Friends of Kara report seeing her around this period with bruises which she said were caused by Stefan. Kara asked them to keep this confidential
2008	Stefan takes steps to change the title deed for their home, so that Kara and Stefan are tenants in common
2009	Stefan alters his Will, removing Kara and her daughter as beneficiaries
2009	Kara and Stefan separate and divide the house into a ground floor flat (Kara) and upstairs flat (Stefan)
2009-10	Stefan states to friends and family on a number of occasions that he has changed his Will because his wife, her brother (now deceased) and her daughter are plotting to have him killed
13/17 January 2011	Kara's daughter reports her concerns to GP1 about the risk to her mother from Stefan and her concerns about the mental state of Stefan
24 January 2011	Kara attends a consultation with GP1 where she inform GP1 about Stefan's paranoid thoughts and discloses experiencing physical violence from him a year earlier.
16 October 2011	Kara's brother dies
17 December 2012 and 11 January 2013	Stefan referred to radiology after complaining of hip and thigh pain
16 January 2013	Radiology report notes Stefan with imminent fracture and possible cancer
17 January	Kara and Stefan attend consultation at Family Practice where

2013	Stefan is informed that he may have cancer
18 January 2013	Stefan buys petrol cans and petrol
21 January 2013	Friend reports seeing Stefan and is concerned that he seems agitated and informs Kara to keep her door locked.
21 January 2013	Friend and daughter report that Kara is distressed at having to accompany Stefan to hospital for tests
21/22 January	Stefan kills Kara, sets fire to their home and takes his own life.

Appendix Two: Terms of reference

Domestic Violence Homicide Review

Terms of Reference

Victim **Kara**

Perpetrator **Stefan**

The London Borough of Barnet as the lead agency and with its partners intends to use Domestic Homicide Reviews to identity opportunities for learning that in turn, reduce the risk to future victims and any children involved.

This review will not seek to apportion blame or vilify any person or agency. The review will be conducted in an open and transparent manner with information shared within the DHR panel.

The legal requirement is set out under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004).

This review, its process and final draft is the responsibility of Barnet Safer Communities Partnership Board (BSCPB).

The nominated agencies will share all information in accordance with section 115 Crime and Disorder Act 1998 and do so without prejudice.

Terms of Reference:

These terms of reference have been developed principally to identify any lessons from this particular case. They are intended to set the direction and minimal requirements of the Review. However, they do not place any restriction on enquiries that the Chairperson and Panel feel would add additional useful information and opportunities for learning.

We will examine how effectively Barnet's Borough's statutory agencies and Non-Government Organisations work together and individually.
We aim to:

- establish whether there are lessons to be learned about the way in which local professionals and agencies worked together and individually to safeguard domestic violence victims and their children;
- clarify what any lessons are, how they will be acted upon 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 homicide and improve service responses for all domestic violence victims and their children;
- improve inter-agency working and improve protection for domestic violence victims and their children.

Purpose:

The review will seek to safeguard potential victims by

- reviewing policies and processes to improve inter-agency partnership working
- analysing gaps in information and practice
- identifying and sharing lessons on behalf of the Domestic Homicide Panel Members
- recommending areas for improvement
- updating partner agencies accordingly

Confidentiality, disclosure and information sharing:

All parties are bound by a signed confidentiality and information sharing protocol as defined in the Crime and Disorder Act 1998 (as amended by the Police and Justice Act 2006).

A disclosure statement will be signed by all parties at the first meeting. No disclosure outside of the Domestic Violence Homicide Review Panel is permitted unless the owning agency has sought the agreement of the Chair in advance and in writing.

Scope of this review

i. To review events in the 12 month period up to the date of the deaths of Kara and Stefan and bring within the scope of the review any events where it becomes apparent to the Independent Chair that the timescale in relation to some aspect of the review should be extended.

ii. To review the actions of the agencies defined in Section 9 of the Domestic Violence, Crime and Victims Act (2004) who were involved with the family and – at the initiative of the Chair and subject to their agreement – any other relevant agencies or individuals.

iii. To seek to involve the family in a sensitive and considered manner and include their potential contribution to the review in the way set out in Section 7 of the Home Office Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

iv. To produce an overview report which:

- summarises concisely the relevant chronology of events including the actions of all the involved agencies
- analyses and comments on the appropriateness of actions taken
- makes recommendations which, if implemented, will better safeguard families and children where domestic violence is a feature.

v. To complete a final overview report by the end of September 2013, acknowledging that this will be dependent, to some extent, on the completion of agency individual management reviews to the standard and timescale required by the Independent Chair.

1. Circumstances of particular concern

The DHR will focus on the following areas of particular concern, where:

i. There was evidence of a risk of serious harm to the victim that was not recognised or identified by the agencies in contact with the victim and/or the perpetrator, it was not shared with others and/or it was not acted upon in accordance with their recognised best professional practice.

ii. Any of the agencies or professionals involved considers that their concerns were not taken sufficiently seriously or not acted on appropriately by the other parties involved.

iii. The homicide indicates that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency.

iv. The homicide appears to have implications/reputational issues for a range of agencies and professionals.

v. The homicide suggests that national or local procedures or protocols may need to change or are not adequately understood or followed.

vi. The victim had no known contact with any agencies. For example, could more be done in the local area or within specific communities to raise awareness of services available to victims or perpetrators of domestic violence?

2. Independent Chair of the Review Panel

In line with Home Office Guidance published in 2011, the Independent Chair of the Review Panel will be responsible for:

- Managing and coordinating the review process
- Commissioning individual management reviews
- Discussing with relevant criminal justice and/or other agencies (e.g. HM Coroner, Senior Investigating Officer, Independent Police Complaints Commission) at an early stage how the review process should take account of such proceedings
- Producing the final Overview Report based on Individual Management Reviews (IMRs) and any other evidence the Review Panel decides is relevant.

Additional support will be provided by the Review Panel within existing resources in relation to specialist domestic violence, project management and administration.

The Review Panel will monitor the Charing arrangements; if it is felt that these are not working effectively, the Panel will meet to determine an alternative way forward.

3. Equality and diversity

The Independent Chair and members of the Review Panel will bear in mind all equality and diversity issues at all times. These include: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. These may have a bearing on how the review is explained and conducted and the outcomes disseminated to local communities.

4. Membership:

Barnet Domestic Homicide Review Panel Members
Independent Chair – Neil Blacklock
Barnet Council
Children's Services DV Co-ordinator
Adult Social Care
Environment, Panning and Regeneration
Community Safety (Crime and Information Manager)
Metropolitan Police Service
MPS Barnet Community Safety Unit
MPS Specialist Crime Review Group
Housing providers
Barnet Homes
Health
Central London Community Health Trust

Barnet Mental Health Trust
Barnet Primary Care Trust
London Ambulance Service
London Fire Service
Non-Governmental Organisations
Solace Women's Aid, including Jewish Women's Aid and DVIP
Victim Support

Other agencies will be invited to attend if it becomes apparent to the Chair that this will aid the work of the Review.

Attendance by invitation:

From time to time there will be the need for others to attend the review meetings. These people will be formally invited to the meetings and their attendance will be agreed at the previous meeting to that which they attend:

- Officers who may be required to explain or expand on their work
- Other Members of the Council/Partnership
- Project/commissioned services/providers to explain their work.

Governance

The Chairperson will, with the panel, set and review if appropriate the parameters of the Review. The BSCPB or DVSB will monitor the process and sign off the final report agreeing the final circulation list.

Support:

Support will be provided by the BSCPB – who will arrange refreshments, meeting space and a minute taker.

The Chair of BSCPB, The Domestic Violence Coordinator, Chief Inspector and Director of Children's Service will support the panel with information on process and current thinking.

Frequency of DHR Panel meetings:

To be defined at the first meeting of each Homicide Review meeting and reviewed at subsequent meetings – anticipated length of review 6 months.

Agencies' Roles:

Attendance at meetings – deputies **will not** be used to ensure continuity

Agencies to contribute a paper review of their service provision and dealings with the victim/perpetrator(s)

Partner organisations to undertake a management review and submit it for the panel's consideration.

5. Involvement with friends, family members and other support networks

When meeting with friends, family members and others, the Review Panel will:

- Communicate through a designated advocate who has, where possible, an existing working relationship with the family i.e. a voluntary and community sector representative.
- Make a decision regarding the timing of contact with the family based on information from the advocate and taking account of other on-going processes i.e. post mortems, criminal investigations.
- Ensure initial contact is made in person and deliver any relevant information leaflets.
- Ensure regular engagement and updates on progress through the advocate, including the timeline expected for publication.
- Explain clearly how the information disclosed will be used and whether this information will be published.
- Explain how their information has assisted the review and how it may help other domestic violence victims.
- Provide a completed version of the review to the family prior to submitting the report to the Home Office. This will allow consideration of the other findings and recommendations. It is then possible to record any areas of disagreement.
- Maintain reasonable contact with the family, even if they decline involvement in the review process; it will be important to communicate through the designated advocate when the review is completed and when the review has been assessed and is ready for publication. They should also be informed about the potential consequences of publication i.e. media attention and renewed interest in the homicide.

The Review Panel may also wish to access other networks which victims and perpetrators may have disclosed to, for example, employers, health professionals, local professionals involved in Domestic Violence Perpetrator Programmes (DVPPs) or their local VCS agencies.

6. Individual Management Reviews (IMRs)

Agencies will:

- Secure all relevant case records as soon as notification of the DHR is received.
- Begin the IMR as soon as a decision is taken to proceed and once the terms of reference have been set, including a chronology of their involvement with the victim, perpetrator or their families, using the guidance and terms of reference provided by the Independent Chair of the DHR.
- Keep a written record of interviews undertaken in the preparation of the IMR which should be shared with the relevant interviewee.
- Remind staff that the review does not form part of a disciplinary investigation. The views of the SIO and subsequent CPS advice must be sought prior to interviewing witnesses involved any criminal proceedings.
- Ensure that professionals outside the IMR process should contribute reports of their involvement with the victim(s) and/or perpetrator(s).
- Ensure that the officer conducting the IMR has not been directly involved with the victim, the perpetrator or either of their families and should not have been the immediate line manager of any staff involved in the IMR.

The IMR will enable agencies to:

- Look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made/
- Identify how those changes will be brought about.
- Identify examples of good practice within agencies.
- Indicate if disciplinary action should be taken under the agency's established procedures (although this is **not** part of the IMR and should be pursued separately by the agency).

The senior manager of the agency will:

- Quality assure their report, ensuring that any recommendations from both the IMR and, where appropriate, the Overview Report are acted on appropriately.
- Feedback and debrief staff involved in the review, following completion of the IMR, with a follow-up sessions once the Overview Report has been completed and prior to its publication.

7. Overview Report

The Chair of the DHR will:

- Bring together and draw overall conclusions from the information and analysis contained in the IMRs and reports or information commissioned from any other relevant interests into the Overview Report.
- Make recommendations for future action which the Review Panel will translate into a SMART action plan.
- Ensure that the findings are regarded as 'Restricted', in line with the Government Protective Marking Scheme (GPMS) until the date of publication. Prior to this, information should be made available only to participating professionals and their line managers who have a pre-declared interest in the review. It may also be appropriate to share these findings with family members, as directed by the Independent Chair.
- Appoint lead individuals or agencies to take responsibility for engaging with family members and friends, and for responding to media interest about the review, in liaison with contributing agencies and professionals.
- Direct that all media enquiries are to be dealt with by Barnet Council's press office in line with Council's media and PR guidelines.

The Review Panel will:

- Keep personal details anonymous within the final report and Executive Summary.
- Ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the Overview Report.
- Ensure that the Overview Report is of a high standard and is written in accordance with the Home Office Guidance for the Conduct of Domestic Homicide Reviews (April 2011).
- Translate the recommendations in the Overview Report into a specific, measurable, achievable, realistic and timely (SMART) Action Plan, agreed at senior level by each of the participating organisations.
- Ensure that the Action plan sets out who will do what, by when, with what intended outcome; the Panel will also set out monitoring and reviewing arrangements in the Action Plan.
- Provide a copy of the Overview Report, Executive Summary and Action Plan (known collectively as the 'supporting documents' to the Chair of Barnet's Safer Communities Partnership Board (BSCPB).

Appendix Three: Redaction framework for DHR

General principles

1. The DHR's aim is to ensure that a proper analysis of the issues relating to a homicide is obtained which enables lessons to be learned without blame being apportioned. The report is produced in accordance with Home Office guidelines.

2. Any redaction within the report should seek to properly balance rights to privacy and confidentiality in a way which does not affect the proper analysis of agencies' actions and what lessons should be learned.

3. Information already in the public domain should not be redacted retrospectively unless a specific barrier exists in law.

4. Where information is redacted this should be obvious to the reader. The majority of redactions are likely to be in relation to personal data and will in general require no specific explanation. Redactions other than for protection of personal data should be accompanied by a short explanation (at an appropriate place in the report) unless to do so would in itself place a person at risk of harm.

5. The identities of all professionals, family and associates shall be redacted in accordance with a standard scheme which reveals the professional status or family background, but not the name e.g. HV1 for Health Visitor 1; GP1 for General Practitioner etc.

Safety issues

6. Both Executive Summary and Overview Report will be published in accordance with Government guidelines. The nature of the information therefore entering the public domain may be such that children and adults may be placed at risk of harm.

7. If, in the opinion of the report author, facts which might be included in the report could place an individual at risk of harm then s/he shall redact it to remove such concerning information as s/he considers in his/her discretion necessary. The principle shall be that the minimum redaction possible shall be applied, including the use of anonymisation or pseudonyms as an alternative if appropriate.

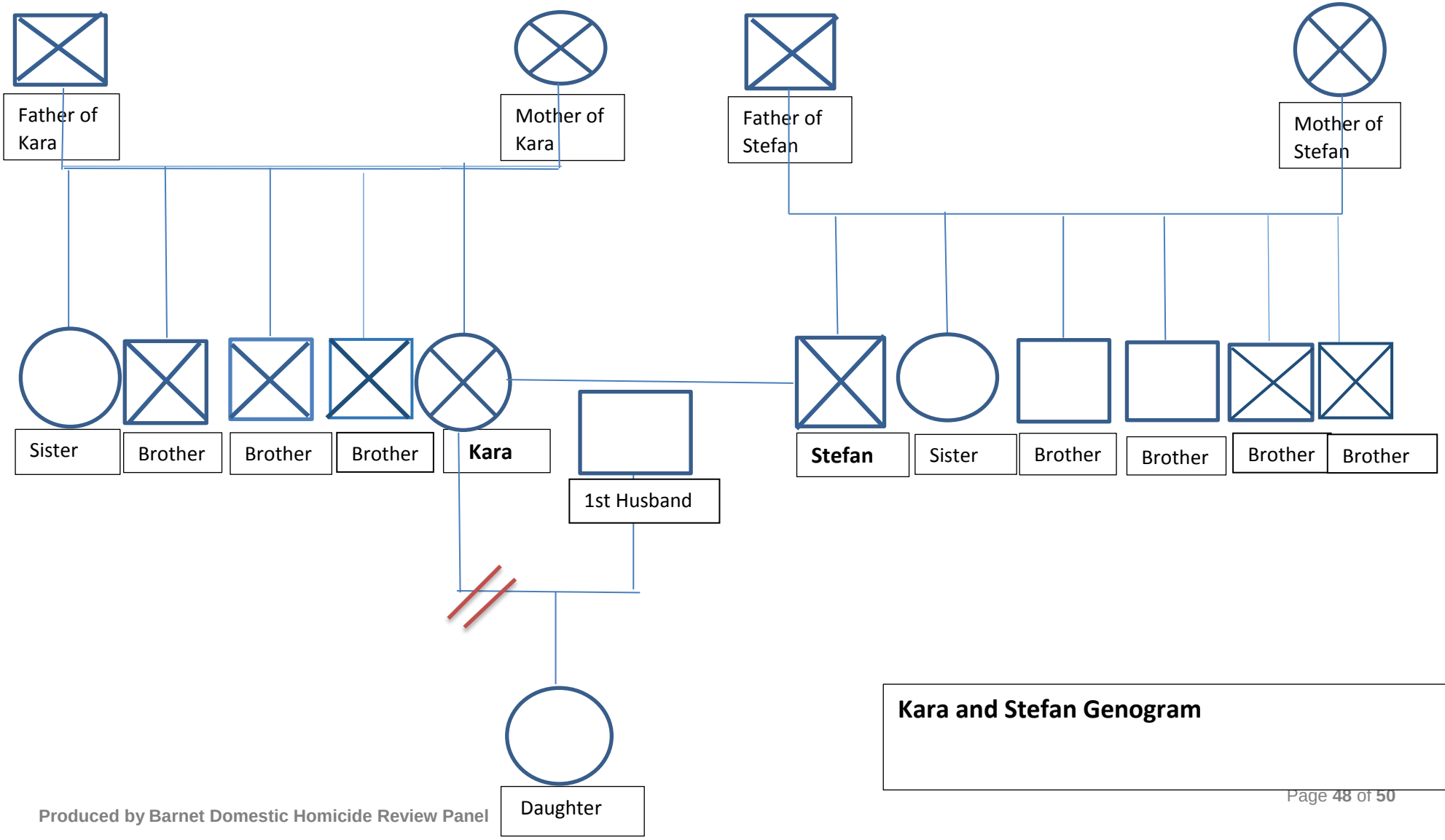
Sensitive personal information, including health information

8. If, in the opinion of the report author, the inclusion of sensitive personal information about living individuals would infringe upon their legitimate expectations as to privacy or their rights to privacy under Article 8 The Human Rights Act 1998 or the Data Protection Act 1998, then s/he shall redact it to remove, edit or amend such concerning information as s/he considers in his/her discretion necessary. The principle shall be that the minimum redaction possible shall be applied, including the use of anonymisation or pseudonyms as an alternative if appropriate.

Audit and moderation

9. The Domestic Violence Co-ordinator shall maintain a list of any such specific redactions which shall be submitted to the DHR Panel for moderation on such frequency as is appropriate to the case.

APPENDIX FOUR – FAMILY GENOGRAM



Kara and Stefan Genogram

Appendix Four: Glossary and abbreviations

MPS – Metropolitan Police Service

LBB – London Borough of Barnet

LFB – London Fire Brigade

SCPB – Safer Communities Partnership Board **this acts as the** Community Safety Partnership for Barnet.

JWA – Jewish Women's Aid

IMR – Independent Management Review - a review of an agencies contact with named individuals, the actions taken and analysis of these action and recommendation for improvements[16]
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97881/DHR-guidance.pdf

DASH. Risk identification checklist, an abbreviation of Domestic Abuse Stalking and Harassment, developed by CAADA and Laura Richards. There is a police version which has 27 items and 24 item version. See http://www.dashriskchecklist.co.uk/ and www.caada.org.uk

DHR. Domestic Homicide Review, in line with Home Office guidance 2011

DVIP. Domestic Violence Intervention Project, a voluntary sector organisation providing a range of interventions for the people using violence and abusive behaviour in relationships. See http://www.dvip.org/

GP1 – The General Practitioner that saw Kara and Stefan the most.

IDVA. Independent Domestic Violence Advisor

IRIS Project. A GP focussed training and referral programme on domestic violence. See http://www.irisdomesticviolence.org.uk/

16

OT – Occupational Therapy. The use of treatments to develop, recover, or maintain the daily living and work skills of people with a physical, mental or developmental condition

MARAC. Multi-Agency Risk Assessment Conference. A multi-agency setting where high risk domestic violence cases are reviewed and strategies developed to reduce risk. See http://www.caada.org.uk/marac/Information_about_MARACs.html

Respect. National membership organisation that develop, deliver and support effective services for; perpetrators of domestic violence, young people who use violence and abuse at home and in relationships and men who are victims of domestic violence. See http://www.respect.uk.net/

FGP – Family General Practice **-** The general practice used by Kara and Stefan

SDVC. Specialist Domestic Violence Court