

# Enfield Community Safety Partnership

## Domestic Homicide Review

Executive Summary

Elizabeth (March 2016)

10 January 2019  
Eleanor Stobart

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# THE REVIEW PROCESS

This domestic homicide review was commissioned by Enfield Community Safety Partnership following the death of a white British woman, "Elizabeth", who died at her home in March 2016. Her partner was found guilty of her murder and in January 2017 he was sentenced to life imprisonment and ordered to serve a minimum prison term of 20 years. This report examines the contact and involvement that agencies had with the victim and the perpetrator between January 2013 and her death in March 2016. In addition to the agency involvement, the report also examined any relevant past history of abuse and incorporated the views, thoughts and questions raised by members of her family.

The review panel wishes to express their condolences to Elizabeth's family and friends following her death. The panel also would like to thank all those who have contributed and assisted with this review.

## Contributors to the review

All agencies that had contact with the perpetrator or victim were asked to submit either an individual management reviews or an information report. All the authors of these were independent of the case i.e. they were not involved in the case and had no management responsibility for any of the professionals involved. In all, individual management reviews, information reports and chronologies were requested from:

- Barnet, Enfield and Haringey Mental Health NHS Trust (BEH-MHT)
- Compass Drug and Alcohol Service Enfield
- Enfield Strategic Safeguarding Adults Service
- Essex Children's Social Care
- General Practitioner (GP)
- Hertfordshire Community Rehabilitation Company (CRC)
- London Ambulance Service
- London Community Rehabilitation Company (CRC)
- Metropolitan Police Service
- Multi-Agency Risk Assessment Conference (MARAC)
- North Middlesex University Hospital NHS Trust (A&E)
- One Support
- Royal Free London NHS Foundation Trust
- Solace Women's Aid – Independent Domestic Violence Advisor Service
- Westminster Drug Project

## Review panel

The panel met five times. All members were independent of the case i.e. they were not involved in the case and had no direct management responsibility for any of the professionals involved at the time. The review panel comprised:

- Eleanor Stobart, Independent Chair and Author
- Alan Brown, Associate Head of Mental Health, One Support
- Andrea Clemons, Head of the Community Safety Unit, London Borough of Enfield (LBE)
- Andy Bishop, Substance Misuse & IOM Development Manager, Drug and Alcohol Team, London Borough of Enfield
- Aveen Gardiner, Area Manager, London Community Rehabilitation Company (CRC)
- Candice Donn, Enable (Drug and Alcohol Service in BEH-MHT)
- Carole Bruce-Gordon, Acting Director of Quality and Governance, Enfield Clinical Commissioning Group
- Craig Emmerson, Acting Detective Inspector, Enfield Metropolitan Police
- Deirdre Blaikie, Adult Safeguarding Lead, Royal Free NHS Trust
- Helen Rendell, Detective Sergeant, Metropolitan Police Service
- Joanna Stronach-Lenz, Public Health Strategist, Public Health, London Borough of Enfield
- Julie Dalphinis, Interim Adult Safeguarding Lead, Enfield Clinical Commissioning Group
- Ruth Vines, Head of Safeguarding, Barnet Enfield & Haringey Mental Health NHS Trust
- Sandjea Green, Senior Manager, Solace Women's Aid
- Sarah Pope, Safeguarding Adults Lead, North Middlesex Hospital NHS Trust
- Shan Kilby, Domestic Violence Coordinator, Community Safety Unit, London Borough of Enfield
- Sharon Burgess, Head of Safeguarding Adults, London Borough of Enfield

## Author of the overview report

The chair/author of this review has been a freelance consultant for 17 years. She specialises in safeguarding children and vulnerable adults with a particular focus on domestic abuse and working with minority ethnic families. She has chaired and authored over 15 serious case reviews/domestic homicide reviews. Eleanor has a Master of Business and Administration (MBA) from Bradford University School of Management (2000) and a Master of Laws (LLM) in Child Law from Northumbria University (2011).

Eleanor is independent of, and has no connection with any agency in Enfield; she has never been employed by any agency in Enfield.

## Terms of reference for the review

The aim of the review was to:

- i. Establish what lessons can be learned from Elizabeth's death about the way in which local professionals and organisations work individually and collectively to safeguard victims
- ii. Identify how and within what timescales those lessons are to be acted on, and what is expected to change as a result
- iii. Apply these lessons to service responses including changing policies and procedures as appropriate
- iv. Prevent domestic homicides and improve the way services respond to all victims of domestic abuse and their children, through improved intra and inter-agency working<sup>1</sup>

## Key lines of enquiry

The individual management reviews and information reports addressed both the "generic issues" set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- What knowledge or information did your agency have that indicated Elizabeth might be at risk of abuse, harm or domestic violence and how did your agency respond to this information?
- If your agency had information that indicated that Elizabeth might be at risk of abuse, harm or domestic violence was this information shared? If so, with which agencies or professionals?
- In what way did your agency's knowledge of Elizabeth's history influence professionals' decision making?
- How did your agency assess whether Elizabeth was able to articulate what was happening in her life (on those occasions when she accessed services whilst under the influence of drugs or alcohol)?
- What knowledge or information did your agency have that indicated the perpetrator was violent, abusive or might cause harm to someone and how did your agency respond to this information.
- If your agency had information that indicated that the perpetrator was violent, abusive or might cause harm to someone, was this information shared? If so, with which agencies or professionals?
- What opportunities and services did your agency offer and provide to meet the needs of Elizabeth and the perpetrator? Were they accessible, appropriate, empowering and empathetic to their needs and the risks they faced?
- Were there issues of capacity or resources within your agency that had an impact on your agency's ability to provide services to Elizabeth or the perpetrator? Did capacity or resources have an impact on your agency's ability to work effectively with other agencies?

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<sup>1</sup> Domestic homicide reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and courts

## BACKGROUND AND SUMMARY CHRONOLOGY

Early one March morning in 2016 police were called to an address in Enfield. Elizabeth had been stabbed in the abdomen and had sustained severe facial injuries. London Ambulance Service was at the scene and pronounced Elizabeth dead 30 minutes later. Elizabeth was 42 years old.

Elizabeth's partner was arrested at the scene and subsequently charged with her murder. He was found guilty in January 2017 and sentenced to life imprisonment with a minimum term of 20 years.

Elizabeth lived in Enfield. She had two children who were both subject to residence orders and lived with Elizabeth's mother in Essex. Elizabeth continued to have contact with them. Elizabeth was known to mental health services. She had a diagnosis of bi-polar disorder and she had a history of self-harm. She was dependent on alcohol as well as a number of prescription drugs. Over the years, she worked hard to reduce her dependence on them and by 2015 she only drank one glass of wine or a can of cider a day.

Both Elizabeth and her partner were known to police. Elizabeth had ten previous convictions for 18 offences. These mostly concerned offences such as shoplifting and drink driving. During the period under review, she was charged with theft, possession of cannabis and common assault for which she received a 12-month supervision order, a six-month alcohol treatment order and a restraining order.

The perpetrator had 29 convictions for 84 offences. These included criminal damage, burglary, arson, drink driving and actual bodily harm. He had been given prison sentences on numerous occasions. Most notably in 1995 for arson (18 months), 1997 for actual bodily harm (18 months), 1999 for burglary and theft (5 years), 2009 for burglary (876 days), 2011 for burglary (4 years) and in 2013 for burglary (2 years). Whilst under the supervision of London Community Rehabilitation Company (CRC), he was registered as a persistent and prolific offender (PPO).

It appeared that the perpetrator met Elizabeth sometime around the beginning of 2013. Between 2013 and the time of Elizabeth's death in 2016, police were called to five incidents when the perpetrator had assaulted Elizabeth. In April 2015, the perpetrator was recalled to prison following an assault on Elizabeth. Her case was heard at the multi-agency risk assessment conference (MARAC) in August 2015. He was then released in November 2015. At the time of his release he was managed by Enfield Integrated Offender Management (IOM) and London Community Rehabilitation Company (CRC); Elizabeth was supported by the London Community Rehabilitation Company (CRC) together with Westminster Drug Project, One Support, the independent domestic abuse advisor (IDVA) and Barnet, Enfield and Haringey Mental Health NHS Trust.

## EMERGING THEMES AND LESSONS LEARNT

### 1. Co-ordination of cases and sharing information

There were many agencies and practitioners working to support Elizabeth and to a lesser degree, the perpetrator. Nevertheless, the co-ordination and information-sharing around Elizabeth was ineffective. There was no evidence of professional discussions or a professionals' meeting being convened. There were missed opportunities from all agencies to come together to understand Elizabeth's experience and the effect the perpetrator's violence and abuse was having on her.

## 2. Inaccurate spelling of names and the use of aliases

The perpetrator used up to 13 different aliases. This made it hard for agencies to identify him, to follow his movement and collate his actions. There was no doubt that the perpetrator used aliases to prevent agencies gaining a clear picture of his movements. To compound matters, Elizabeth's name was spelt in six different ways in her records and distressingly for her family, it was even spelt incorrectly on her death certificate.

## 3. Drugs and alcohol, mental health and domestic abuse

Elizabeth had a long history of mental health problems. This, along with her drug and alcohol use, may have influenced professionals' response to her injuries i.e. they appeared to accept that they were either due to self-harm or as a result of being under the influence of drugs or alcohol; therefore, the possibility that the perpetrator may have inflicted them was never considered.

Both Elizabeth and the perpetrator were heavy drinkers. Agencies focused on the alcohol and did not recognise that the victim was drinking to cope with the abuse. Clearly, neither issue can be wholly addressed unless the accompanying abuse or alcohol misuse is taken into consideration.

## 4. Non-engagement with services

Elizabeth was frequently asked to self-refer to services (i.e. mental health services and the drug and alcohol service). While signposting can be useful, it was not an adequate response to Elizabeth who was vulnerable and at risk. There are a large number of factors that might act as barriers to people engaging with services including a lack of belief in the ability to change, anxiety or depression. Another barrier can be perpetrators subverting efforts to change. Often perpetrators may simply not allow the victim to attend appointments.

## 5. Coercive control

Professionals underestimated the level of coercive control in the relationship. There appeared to be a correlation between Elizabeth decreasing engagement with services and the perpetrator's release from prison. It is likely that he prevented her (or at least hampered her) from attending appointments. It was also evident that he "*coached her*" when providing explanations of her injuries.

The perpetrator also appeared to control and manipulate the professionals around him. He certainly managed to evade scrutiny.

## CONCLUSION

This domestic homicide review has been complex and upsetting. Elizabeth was a vulnerable woman who was open to seeking help and changing her life. When the perpetrator was in prison, she came close to realising her goals. However, the lack of systems in place actually thwarted her attempts not only to change, but to extricate herself from her relationship. Some panel members thought that stretched budgets may have played a role in the way Elizabeth was "pin balled" between services,

whilst other thought that it was sheer incompetence. Whatever the case, the lack of a coordinated response had an impact on every aspect of her life – it meant that no one realised that the perpetrator was using false names, it meant that no one noticed her name was being spelt incorrectly; it meant that the domestic abuse, the use of drugs and alcohol and Elizabeth's mental ill health were all viewed in isolation; it meant that no one considered her children and the risk they faced; it meant that no one addressed her difficulties engaging with services; and ultimately it led a total lack of information sharing between agencies.

## RECOMMENDATIONS

- i. The key agencies within this review must consider how complex cases are managed and report back to the Community Safety Partnership by March 2018
- ii. Within 18 months, the Community Safety Partnership should evaluate whether complex cases are being managed more effectively
- iii. The multi-agency risk assessment conference (MARAC) meeting should consider how to share any pertinent information with the relevant GPs.
- iv. The individual management reviews in this case were particularly poor. The Violence Against Women and Girls Group should consider providing multi-agency training to improve agency's understanding of the process
- v. Staff in Accident and Emergency Departments should receive training about self-harm and self-harm should be included in all local domestic abuse training. (This should ensure that staff have an understanding of unusual self-inflicted injuries (e.g. Elizabeth's facial injury) or 'accidental' injuries).
- vi. The Community Safety Partnership should consider funding a domestic abuse advocate/educator for the Accident and Emergency Department at North Middlesex Hospital
- vii. Elizabeth's mother and daughter had a number of questions they wanted answered about the chain of events following Elizabeth's death (see overview report s.2.2.1.). The Metropolitan Police Service should consider how best to address those questions.
- viii. Enfield Community Safety Partnership should ask each agency involved in this review to provide feedback on their single agency recommendations.

Agencies identified a number of opportunities for areas of improvement and 23 single agency recommendations arose from this domestic homicide review.

These single agency recommendations addressed a wide range of issues including (amongst other things) fostering closer liaison between professionals working with perpetrators and those supporting victims, improving responses to disclosures of domestic abuse, offering timely assessment appointments, further developing training on domestic abuse and flagging records

where domestic abuse, mental health and/or substance misuse are a feature. There were also recommendations about improving handovers between professionals when workers leave and highlighting the importance of maintaining consistent and meaningful working partnerships between key agencies.

Work has already started to improve practice in some of these areas. Nonetheless, Enfield Community Safety Partnership will ensure that agencies implement all the recommendations, which are set out in full in the attached action plan.