		AGENDA ITEM: 6
Report Name:	Recommendation and actions in response to the: Domestic Homicide Review (DHR) into the death of Kara and Stefan (pseudonym names).	
Meeting:	**Barnet Safer Communities Partnership Board 9SCPB)**	
Meeting Date:	31 October 2014	
Report Author:	Manju Lukhman – Domestic Violence Co-ordinator	
Responsible Officer:	Jo Pymont Interim Assistant Director Children's Social Care	
Outcome Required:	Information Only: Decision Required: **Feedback/comments required: X**	
Restricted	No	

1. Report Summary

1.1 Report on the Domestic Homicide Review (DHR) into the death of Kara and Stefan (pseudonym names).

1.2 This Domestic Homicide Review (DHR) examined the circumstances leading up to the death of Kara (victim) and Stefan at their home.

1.3 The review considered all contact/involvement of the agencies with them prior to their death. Family and friends were also involved. Barnet's Safeguarding Adults Board decided that there was no need to run a parallel serious case review.

2. Role of the SCPB

2.1 The DHR has been cleared from the Home Office Quality Assurance Group. The recommendations from the review have been incorporated into an action plan which will be monitored by the Domestic Violence and Violence against Women and Girls Delivery Board on behalf of the SCPB.

2.2 Once this report has been approved at the SCPB meeting on 31st October 2014, the executive summary of the DVHR report will be publicised on SCPB web page.

2.3 There are a number of recommendations contained within the report that the Safer Communities Partnership Board (SCPB) have a duty to ensure are responded to. A list of the recommendations and the actions agreed are attached as *appendix 1* of this report.

2.4 The Domestic Violence and Violence Against Women and Girls (DV & VAWG) Delivery Board (a subgroup of the SCPB) is responsible for ensuring that the recommendations are implemented and updating the SCPB on progress.

2.5 There are no statutory obligations on the timings relating to the publication of the report. However partners are keen to expedite this swiftly.

3. Recommendations of the DVHR and Updates

3.1 Within the current DHR review partners have found it challenging in obtaining GP Independent Management Reviews (IMRs) / reports.

3.2 Section 7 of the 'Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' states that where agencies have had contact with a victim and/or alleged perpetrator they are required to carry out an IMR. Section 7 (60) instructs that "Those conducting IMRs should not have been 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".

3.3 Although the guidance is less directive in terms of IMRs from GPs and dentists who are considered outside the IMR process, Section 7(59) states that they should contribute reports. It follows that the same principles should apply to these reports i.e. the authorship should be independent.

3.4 Prior to the restructuring of Public Health GPs provided reports following the IMR template supplied in the statutory guidance; this gives a suitable structure to the report. The reports were written by an independent author who was usually a senior health professional within the local Primary Care Trust Safeguarding Department. Since the restructure and formation of Clinical Commissioning Groups in April 2013 the process for obtaining GP reports for a Domestic Homicide Review has become difficult, with different approaches being pursued by different areas; for example some areas have a funding pot from Public Health for the reports to be commissioned from independent authors. In the London Boroughs there are varying processes.

3.5 We have experienced difficulties in obtaining GP practice IMR/reports they are either unavailable or are limited in meeting the terms of reference of the DHR. The issues causing the problems are:

i. In the current DHR The GP practice has been unable to provide a report (they did provide a chronology). It is a small two person GP practice. Both have seen the alleged perpetrator and are therefore inappropriate as authors for a review of the practice and their actions. The GPs in this practice say they cannot afford the fee of an independent author.

ii. NHS England insists the GP's should provide a report as part of their contractual arrangements. The Independent Chair of the DHR and Manju Lukhman – the DV Coordinator have both approached the Home Office for advice and we understand they

are liaising with NHS England, but to date we have not received any advice to resolve the difficulties.

8. In the recent Barnet cases the GP practices had the greatest involvement of any agencies in the case, therefore it is vital to achieve a thorough, independent, and knowledgeable review of their actions and practice to gain detailed knowledge to support learning from the Review. An author of a GP report needs to be independent of the practice and have knowledge of what good practice is in general practice; have knowledge of safeguarding policies and best practice, and be knowledgeable about all aspects of domestic abuse and best practice as it relates to community health and GPs.

4. Recommendation for the SCPB

4.1 It would be most helpful if the Safer Communities Board could consider if there is any support they can offer the DV and VAWG delivery Board to raise this with Public Health and obtain a response and way forward.

4.2 Suggestions from the agencies involved in the DHR's has included (a) find a resolution in this current case if possible, and (b) consider a Pan London approach for obtaining GP reports for DHRs, perhaps with a central unit or cohort of suitably knowledgeable independent authors to call upon to write them

4.3 In relation to the DHR of Kara and Stefan, we seek an agreement from the SCPB to ensure that the DHR into this case is noted, implemented and the recommendations are followed through. We are seeking commitment from SCPB members to ensure operational support is in place to deliver recommendations specifically addressed to them.

4.4 To agree that all the involved agencies learn from this case and consider the matters and recommendations highlighted in the report and support implementation.

4.5 It has been proposed that the Safer Communities Partnership Board (SCPB) consider how access to domestic violence service for older people can be addressed for example awareness raising campaigns – (Barnet has the 2nd highest population of over 65's in London).

5. Kara and Stefan – Case Summary

5.1 Kara was 80 years old 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

5.2 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.

5.3 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.

5.4 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.

5.5 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".

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

5.7 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.

5.8 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.

5.9 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.

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

5.11 On the day of the homicide, 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. 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.

5.12 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.

6. The key local issues that arose from the review included:

i. The risk to Kara was not identified by any of the professionals contributing to this review.
ii. Kara had disclosed domestic violence and abuse issues to her GP (and previous GP).
iii. The need to address DV disclosures to non DV specialist services and how they respond and manage this disclosure and recognise risks.
iv. The need to understand that DV is not just about physical abuse, but follows this definition:

7. Domestic violence and abuse - definition

7.1 “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. This can encompass, but is not limited to, the following types of abuse: Psychological, physical, sexual, financial, and emotional.”

7.2 “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.

7.3 “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.”

7.4 Given this broad definition and the likelihood of multiple agencies engaging with a potential victim of domestic violence, it is important that agencies ensure, through training, that their workforce is able to identify, support and advise victims, address any potential safeguarding issues and challenge attitudes and beliefs that underpin domestic violence and violence against women and girls.

7.5 A number of issues were raised specifically related to older victims of domestic violence for example access to services, agencies response to disclosures of DV from older people and not minimising the disclosure, clarity around certain injuries or emotional issues associated to their age or frailty verses injuries and emotional issues as a result of domestic violence.

7.6 There were also primarily two main national issues that included:

- Guidance needed for health professionals around the use of interpreters and not using family members to act the interpreter.

- The vital role that GPs play when issues are shared by patients, such as depression, stress, suspicious injuries etc. and to explore the root cause of this that could possibly be as a result of experiencing DV.

- A recommendation was presented to health partners via the Health and Well Being Board in September 2014 around a project called IRIS project. . IRIS is a service that supports local areas to address issues such as the need for improved training and awareness on domestic violence and abuse for GPs and healthcare professionals, who do not always know what to do with a disclosure of domestic violence or abuse.