Lincolnshire Community Safety Partnership

Domestic Homicide Review: Executive Summary

The Homicide of Michael

1. INTRODUCTION

1. This report of a Domestic Homicide Review undertaken by Lincolnshire Community Safety Partnership is to review the death of Michael[1] in May 2015, who was killed by his long-term partner, Melanie, who was later charged with the offence of murder. Melanie pleaded guilty to murder and received a sentence of life imprisonment in 2015 and is to serve a minimum of 12 years of this in custody.

2. The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. On a multi-agency basis, professionals need to evaluate and understand the circumstances, agency involvement and lessons to be learnt from each homicide, in order to reduce the risk of further homicides.

3. What we know from agency records is limited, due to a lack of opportunity for multi-agency working, and when opportunities did arise, the assessments of needs were not completed in a comprehensive or holistic manner. There was limited agency involvement with them as a couple, the focus of agencies on their presenting needs and the lack of robust assessment of Melanie's needs as a carer.

4. The review was conducted by a panel with an Independent Chair and representatives with relevant professional roles from:

- Named Nurse for Safeguarding
- Domestic Violence and Abuse Co-ordinator: Police
- Consultant Nurse Safeguarding Children and Adults
- Consultant Nurse Safeguarding & Mental Capacity
- Adults Safeguarding Lead
- Housing and Well-being Service Manager
- Domestic Violence and Abuse Co-ordinator: Community Safety Partnership

[1] Michael and Melanie are pseudonyms to preserve anonymity.

None of the panel had any direct connection with the people, events or decisions covered by the review. The review report draws on information and analyses from the agencies which were involved with either Michael, Melanie or both.

5. After being notified of this domestic homicide, Lincolnshire Community Safety Partnership took the initial steps required for a review, establishing joint chronology of agency contact with Michael and Melanie. The terms of reference were drafted by the panel, and Individual Management Reviews (IMRs) were completed by the following agencies who had significant contact with Michael or Melanie:-

   - East Lindsey District Council (ELDC)
   - United Lincolnshire NHS Hospital Trust (ULHT)
   - Clinical Commissioning Group (CCG)
   - Lincolnshire Partnership NHS Foundation Trust (LPFT)
   - Police
   - Adult Social Care (ASC)
   - Sensory Impairment Lincolnshire County Services (SILCS)

6. The panel drew up an overview report based on these reports, other information about local services and two interviews conducted with Melanie in prison. Extensive efforts were made to identify Michael's family or friends who wished to participate in this review. Melanie's family members were also approached on several occasions in order to provide them with the opportunity to offer their views as part of the review process. All of the family members contacted elected not to participate in this review. Beyond the information in the IMRs and Melanie's self-reporting there is limited information about Michael, his life and his perspectives. As part of the analysis, the panel addressed equality and diversity factors by recognising the impact of disability resulting from physical and mental health problems.

2. CIRCUMSTANCES OF THE HOMICIDE

7. Michael and Melanie essentially present as an isolated couple with limited friends or family living in the local community, with only his sister and brother living locally. Michael was 68 years old, a widower, who had no children. He lived with his partner, Melanie, 66 years old,

with whom he had been in a relationship for approximately 20 years, with approximately 15 years of their relationship spent living in Lincolnshire. Despite the length of their relationship, there is limited record of in-depth knowledge of the nature of their relationship. It is felt that not enough is known about the victim independently from what the perpetrator has said about him and about their relationship.

8. There is limited information of the wider family histories of Melanie and Michael. However, there are several references to the significant loss experienced by Melanie following the death of two of her daughters. It would appear that Michael's attitude and negative reference to Melanie's family was upsetting for her and often a trigger for their arguments and her violence towards him. There is evidence of Melanie's fluctuating mental well-being, caused by the stress and strain of her caring role for Michael. However, the impact of their relationship, Michael's health needs, Michael's substance misuse, Melanie's loss and her subsequent caring role were left generally unexplored by the agencies coming into contact with them.

9. Both had experienced physical health concerns, with Michael experiencing several episodes of chronic physical illnesses. His health issues were complex, further perpetuated by his persistent and chronic alcohol misuse. Despite several attempts by Health practitioners to provide lifestyle advice and support to change his behaviour, Michael was unable to cease his alcohol misuse, which fluctuated, but remained high throughout.

10. Melanie has criminal offences dating back to 1973, ranging from theft to a wounding offence to a previous intimate partner in 1988. In 2005 she was cautioned by the police for an assault on Michael. Evidence reflects episodes of physical violence and, as an outcome of these incidents; Michael suffered minor injuries on several occasions, including burn marks to his face, heavy bruising and minor burn marks to his left arm. Michael had no previous convictions, although Melanie asserts that he had been verbally abusive towards her and had assaulted her several times.

3. AGENCY INVOLVEMENT

11. There were three key periods of agency involvement, in 2002, 2005 and 2015. During these limited opportunities for multi-agency working, there was no requirement identified to trigger the MARAC2 or any other multi-agency process. During the course of their relationship, a DASH assessment3 was completed on one occasion in 2012 (on Melanie as the victim). Several agencies were involved with the couple, but with the exception of the police contact, the role of ELDC to support both their housing needs, they accessed services on an individual basis. Michael had received assessment and support from Lincolnshire County Council's (LCC) Adult Social Care (ASC), from SILCS and Occupational Therapy, whilst Melanie accessed support from Lincolnshire Partnership NHS Foundation Trust (LPFT) for mental health needs.

12. Further scrutiny of the information indicates that the couple were seen together by Health professionals (GP, hospital based consultants, to address various issues regarding their physical needs), police and SILCS. With the exception of historical or minor police incidents, the police responded to domestic incidents involving both parties on three occasions, with the most recent visit dated early 2012. As a result, there were limited opportunities for agencies to observe, assess and understand the dynamics and nature of their relationship.

13. Despite this limited face to face contact with them as a couple, there are two aspects that warranted further assessment and analysis of their needs:-

    - The quality of the adult social care assessments, the lack of focus on face to face contact with Michael and the limited professional curiosity to gather a holistic picture of their care and support requirements beyond a superficial presentation of needs.

    - Despite examples of responding well to Melanie's needs, there was an overall lack of professional curiosity by LPFT clinicians to complete a risk and carer assessment with Melanie. Melanie openly voiced her concerns to LPFT of the 'issues' relating to her partner which impacted on her low mood and her ability to cope in this relationship. The completion of these holistic assessments may have provided further information to

indicate the signs and symptoms of abuse. LPFT generally did not recognise the opportunities to complete a DASH risk assessment or a Carer assessment.

4. CONCLUSION

14. There was sporadic evidence from agency records to reflect the degree of acrimony and abuse within their relationship, with pieces of information shared with the Police and Health regarding the abuse. From the information it would appear that the key trigger to the abuse within their relationship was their alcohol misuse, the pressure of the caring responsibility on Melanie and the verbal abuse within the relationship. Michael was registered disabled and had a range of physical, mobility and personal needs. Their relationship was volatile and shaped by a history of domestic violence and abuse, with the police called on several occasions and allegations made by both parties, but neither pursued their complaints further.

15. At the time of Michael's death the police had attended several previous incidents of domestic violence and abuse involving him, the earliest of which occurred more than 13 years beforehand. Michael was arrested by the police during two of those cases and Melanie was arrested on another. Neither the victim nor the perpetrator was subject of a MARAC. There have been a total of 12 domestic abuse incidents recorded by the Police over almost a 20 year period and the last recorded incident prior to the murder occurred more than 3 years beforehand, in January 2012. In that case the risk was correctly assessed as being medium and it was the only domestic abuse related incident brought to the attention of the police for nearly 7 years. The most serious incident referred to in this IMR was the wounding offence committed by Melanie against a previous partner in 1988. The existence of that offence, however, was not known to the officers who dealt with the incidents during this review period, and details of Melanie's previous convictions did not materialise on her record until after the murder investigation commenced.

16. The issues within their relationship were further compounded by the environmental factors, specifically Michael's continued chronic substance misuse and Melanie's fluctuating depression and self-harm. There are several examples of Melanie physically assaulting Michael, venting her anger and threatening harm. There was a general sense that she was reaching her threshold regarding her tolerance of him. The sentencing comments at

Melanie's trial also note that the presented information reflected that Melanie had also been a victim of domestic abuse, often involving vicious and hurtful verbal abuse by Michael. However, due to the lack of comprehensive assessments of their needs the actual dynamics of their relationships remains unknown. This highlights the function and value of comprehensive assessment focused on the holistic needs of the family as a whole.

17. In conclusion, from the information reviewed it would not have been possible for any agency to predict or prevent Michael's death. However, LPFT and Adult Social Care were in a position to access or offer comprehensive assessments, which may have assisted in offering support to alleviate the emerging stress, strain and anxiety within their relationship.

5. RECOMMENDATIONS

18. The IMRs have provided evidence of actions already undertaken in response to individual agency recommendation. These recommendations have been identified by each IMR author in their own reports and have been signed off at a senior level within the respective agency. The Overview Author's recommendations are focused on improving and developing practice.

R1: ASC to review compliance with their assessment and review procedures, including some Quality Assurance of OT Assessments.

R2: ASC to review their performance or contract review methods for external providers, in particular around the quality of assessments and recording, with a key focus on their quality standards principles.

R3: All relevant agencies to undertake a dip audit sample of the quality of Domestic Abuse Incidents and the completion of DASH risk assessments, ensuring it captures a review of the DASH assessment being completed on the right person (victim) or both (in cases of dual reporting).

R4: ASC to produce a briefing note to be circulated to all agencies on the definition of carers, their roles, responsibilities and how they can access services.

R5: LPFT and CCG to review and align their practice of addressing the needs of carers, including arranging assessments for carers which address their own substance misuse or mental health needs.

R6: As part of the domestic violence and abuse training, all agencies to be alerted to the increased risk for abuse in a caring relationship when the carer is a partner and to pay particular attention to older people's experiences and specific needs.