safe & sound

Dudley's Community Safety Partnership

Executive Summary of the Domestic Homicide Review under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of a woman in December, 2015

Report produced for Safe and Sound, Dudley's Community Safety Partnership by Paula Harding
Independent Chair and Author
April 2017

GLOSSARY

AAFDA: Advocacy After Fatal Domestic Abuse
CSP: Community Safety Partnership
CCG: Clinical Commissioning Group
CPS: Crown Prosecution Service
DA: Domestic Abuse
DSAB: Dudley Safeguarding Adult Board
DSCB: Dudley Safeguarding Children Board
DoH: Department of Health
DHR: Domestic Homicide Review
EMIS: Clinical software used in healthcare settings
GP: General Practitioner
IMR: Individual Management Review – reports submitted to review by agencies
IRIS: Identification and Referral to Improve Safety - a general practice-based domestic violence and abuse training support and referral programme
Safe and Sound: Dudley's Community Safety Partnership

Contents

REPORT PROCESS

1. This summary outlines the process undertaken by a domestic homicide review panel in Dudley in reviewing the homicide of a woman who was a resident in their area.

2. Preferred practice would be for the bereaved family to choose an appropriate pseudonym for the victim, enabling her to be more personalised in the narrative of the review. However, as there was no family engagement in this particular review, the review panel considered it inappropriate to proffer a pseudonym, on this occasion preferring the use of the nomenclature, victim.

3. This domestic homicide review concerns the death of the victim, a 54 year old, white British[1] woman and mother of four grown-up children, who was brutally killed by her husband as she made plans to leave him. Her husband was found guilty of her murder and sentenced to life imprisonment but committed suicide on the one year anniversary of the murder. In summing up the criminal case, the judge highlighted the particular ferocity of the attack and the callous lack of empathy displayed by the perpetrator.

4. The process of the review began with an initial meeting of the Community Safety Partnership Domestic Abuse Core Group on when the decision to hold a domestic homicide review was agreed. All agencies that had potentially had contact with the victim and perpetrator prior to the point of death were contacted and asked to confirm whether they had involvement with them.

5. Four of the thirteen agencies contacted confirmed prior contact with the victim or perpetrator and were asked to secure their files.

CONTRIBUTORS TO THE REVIEW

6. In light of their contact with the victim prior to her death, an independent management review (IMR) and comprehensive chronology was provided by the following organisations:

    - The Dudley Group NHS Foundation Trust in respect of Accident and Emergency Services
    - Dudley Clinical Commissioning Group in respect of the relevant primary care services

7. The IMRs were authored by professionals who had not had any direct contact or management involvement with the victim or her family.

8. A chronology and/or information reports were provided by:

[1] White British is an ethnicity classification used in the 2011 United Kingdom Census

- Dudley Children's Social Care
- Dudley Safe and Sound (Community Safety Partnership) in respect of public information and awareness raising undertaken on domestic abuse in their area.
- National Probation Service in respect of the pre-sentence report for the perpetrator following the homicide.
- West Midlands Police in respect of the limited contact prior to the death; the findings of the criminal proceedings and a verbal indication of the judge's summing up upon sentencing the perpetrator.

THE REVIEW PANEL MEMBERS

9. The review panel members were:

- Paula Harding, Independent Chair and Overview Author
- Anne Harris, Head of Adult Safeguarding, Dudley Metropolitan Borough Council
- Gillian Davenport, Detective Chief Inspector, West Midlands Police
- Jane Atkinson, Designated Nurse For Safeguarding Adults, Dudley Clinical Commissioning Group
- Judith Holloway, Adult Safeguarding Team Manager, Dudley Metropolitan Borough Council
- Katriona Lafferty, Community Safety Officer for Reducing Vulnerability, Dudley Metropolitan Borough Council
- Nikki Penniston, Regional Manager, Black Country Women's Aid
- Sarah Mantom, Vulnerable Adult and Child Specialist Practitioner, Dudley and Walsall Mental Health Partnership NHS Trust
- Susan Haywood, Head of Community Safety, Dudley Metropolitan Borough Council
- Viv Townsend, Head of Sandwell and Dudley Local Delivery Unit, National Probation Service
- DHR Administrator, Birmingham City Council (taking minutes only)

10. Panel members had not had any direct contact or management involvement with the victim or her family and they were not the authors of the IMR reports.

11. The review panel met on four occasions.

AUTHOR OF THE OVERVIEW REPORT

12. The Independent Chair and Author is Paula Harding. She is a senior manager with Birmingham City Council, with responsibilities for strategically addressing violence against women and girls and, for the past five years, she has managed Birmingham's Domestic Homicide Review Team.

Paula Harding has over twenty five years' experience of working in domestic violence with local authority and third sector experience spanning: working in refuge, advice and outreach services; management of front-line services; training and development; information management; policy formation and strategic commissioning. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, specialising in domestic violence and social welfare, and is a regular contributor to conferences, national consultations and academic research.

13. Beyond this review, Paula Harding is not employed by any of the agencies of the Dudley Community Safety Partnership. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office: *Conducting a Homicide Review*[2].

TERMS OF REFERENCE FOR THE REVIEW

14. The review sought to address both the 'circumstances of a particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2013 and 2016) and the following specific issues identified in this particular case:

- What can be established about the nature of the victim and her husband's relationship in recent years?
- What can be established about how the victim understood her experiences and what prevented her from seeking help?
- How might agencies have identified the existence of domestic abuse from other issues presented to them and how might they have responded?
- How is information and awareness raising about domestic abuse reaching Dudley's communities?

15. Individual Management Review Authors were therefore be asked to consider:

- What knowledge or information did your agency have that could have indicated that the victim was at risk of domestic violence and abuse and how did your agency respond to this information?

- How might your agency have identified the existence of domestic abuse from other issues presented to you and how might your organisation have responded?

[2] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

- What services did your agency offer and provide to meet the needs of the victim? Were they accessible, appropriate, empowering and empathetic to her needs and the risks she may have faced?

- Were there issues of capacity or resources within your agency that had an impact on your agency's ability to provide services to the victim?

- Have there been any changes in the way that your organisation responds to domestic abuse in the intervening time period?

16. The panel agreed that the review should focus on the contact that agencies had with the victim for the five years prior to her death with the primary care response to the victim's alcohol misuse considering all relevant prior contact. In view of the little agency contact with the family, wider information on the history of the victim's relationship with the perpetrator; historic information and information on domestic abuse in the perpetrator's previous relationships was also sought to inform the review. Any significant information which might come to light during the review outside the set timeframe was to be agreed by the review panel for inclusion if determined to be of relevance.

SUMMARY CHRONOLOGY

17. The victim met the perpetrator in a casino nearly thirty years ago where the victim was working as a croupier. At the time, the victim was married to her first husband and had two young children. The perpetrator, who described himself as a professional gambler, is thought to have romantically pursued her and eventually they started a relationship, only to be discovered shortly afterwards by her first husband, who went on to divorce her.

18. During the couple's early relationship at the start of the 1990s, it was evident that police and children's social care were aware of domestic violence and abuse and the perpetrator's history of domestic violence. From the sparse records that remain from this time, it is clear that the victim was frightened of the perpetrator who had tried to strangle her. She was asked by children's social care to end the relationship with the perpetrator in order to protect her children; all criminal charges against the perpetrator; no investigation apparently undertaken into the violence against her and her ex-husband was granted custody of the two children with whom she had little future contact.

19. The couple went on to marry, to have two sons, to build up a successful business and enjoy a relatively wealthy lifestyle. However, the criminal proceedings heard that in the following years of the couple's marriage, the victim went on to flee the family home on a number of occasions because of domestic violence. On each occasion she fled to neighbours, with the two very young children of this marriage, but there was no record of her having approached

any statutory or voluntary agency at the time, nor of any concerns having been raised regarding her children as they progressed to school.

20. In the intervening years there was no relevant contact between the family and agencies beyond routine health concerns.

21. Between 2006 and 2015, the victim attended her GP for regular health checks which commonly featured complaints of stress, weight management and unexplained aches and pains. Her alcohol intake was routinely screened during these attendances and consumption fluctuated over the years, with a peak of seventy units of alcohol per week in 2006.

22. The victim attended the Hospital Emergency Department with physical injuries on two occasions and continued to attend her GP for regular health checks until her death in December 2015.

23. The homicide occurred as the victim was planning to end the relationship. The forensic post mortem revealed that the victim had received sixteen hammer blows to her head and crushing injuries to her ribs. Whilst the perpetrator admitted his guilt to the murder, he said that he had been provoked and he knew that his wife was going to leave him.

KEY ISSUES ARISING FROM THE REVIEW

Known domestic violence, abuse and coercive control

24. This domestic homicide review has been limited by the absence of evidence of domestic violence and abuse in the decades prior to the victim's death. However, from the evidence of domestic violence in the early relationship and the perpetrator's known history of domestic violence, it has been possible to draw a picture of a victim who lost custody of her children when she did not leave her husband as required during child protection proceedings. At the time she was known to be frightened of a very violent man who had attempted to strangle her when she withheld sex. It is not known how readily she gave up custody of her two children nor indeed whether that was her preference, but it can reasonably be deduced that she was not made safe by the agencies that she had contact with. How far these experiences affected her future lack of contact with state agencies in the intervening years cannot be known.

25. As the relationship progressed, indicators of physical violence diminished but accounts of the perpetrators behaviour can now be seen as consistent with a pattern of coercive control, namely: isolation from friends and family; possessiveness, jealousy and surveillance ;

systematic monitoring of the victim's daily life; financial control and hyper-control over the household and business.

Missed opportunities for enquiry in health services

26. No agency was aware of any issues of domestic abuse within this family since early 1991 but analysis of the victim's engagement with her GP and Hospital Emergency Services have suggested that there could have been opportunities for further enquiry into the victim's presenting problems.

27. For the GP practice, no consideration appeared to have been given to potential indicators of abuse despite regular accounts of stress, non-specific pain and variable alcohol intake.

28. For the Hospital Emergency Department, the victim's attendance in 2004 for a head injury with an inconsistent explanation and an aggressive accompanying husband would, with today's knowledge of domestic violence and abuse, warranted seeing the victim on her own and asking direct questions about domestic abuse. Her next attendance in 2014, involved an injury that was wholly consistent with her explanation, her husband was still in attendance with her. In this way she did not have an opportunity to be routinely questioned on domestic violence.

Alcohol Misuse as a Potential Indicator of Domestic Abuse

29. The victim's variable level of alcohol intake featured regularly in GP records over the years and at times her alcohol consumption was significantly above the recommended amounts. Alcohol also featured as explanation for the head injury presented in the 2004 presentation to the Hospital's Emergency Department of the victim having fallen when she was drunk and experiencing a head injury

30. The connection between domestic abuse and alcohol misuse is increasingly understood in the literature with alcohol commonly being used by victims as a means to cope and to dull the physical and emotional pain of domestic violence and abuse.

31. Although, health services might be forgiven for not knowing about these connections in the earlier decades of their contact with the victim, the GP practice either missed the opportunity to enquire as to why alcohol use increased so markedly at different times or failed to record the reason and the advice subsequently given.

32. Likewise the Hospital Trust noted that on several occasions, the victim did not complete the aspect of the patient's questionnaire regarding alcohol consumption. This questionnaire assists clinicians in taking the patient's history and the absence of information on alcohol

consumption denied the possibility of exploring potential alcohol misuse with the victim which could itself assist with the identification of any potential abuse.

Community Awareness of Domestic Abuse

33. Coercive control may have been a feature of the couple's relationship, yet no-one identified the observable behaviours as potential domestic abuse. The Community Safety Partnership was able to provide details of a wealth and variety of activities undertaken in promoting community awareness of domestic abuse and coercive control since 2007. More recently, greater efforts have been made by Dudley's agencies to reach into communities, through a 'Community Champions' initiative and through targeted campaigns with hairdressing salons and local businesses. Although this type of facility may not have helped the victim in this case, as the perpetrator always accompanied her to her hair appointments, the wider availability of information in public places and greater awareness for friends and relatives may also have had some influence.

CONCLUSION

34. This domestic homicide review is unusual in so far as the existence of domestic abuse and coercive control within the relationship between the victim and her husband over the two decades prior to her murder is indicated but not proven. Nonetheless, the indications are realistic. The perpetrator had a history of extreme violence and threat towards his former partner and this behaviour continued into his early relationship with the victim and later behaviours of jealousy, surveillance, isolation from friends and family and control over finances were consistent with ongoing coercive control.

35. Ultimately, the perpetrator's brutal murder of his wife following her attempt to end the relationship was the ultimate manifestation of control. With the benefit of hindsight, there is therefore a reasonable probability that the perpetrator continued to control the victim throughout their marriage and some of the victim's health concerns would be consistent with this possibility.

36. The review has established that the victim told no known agency about any abuse after the period in the early 1990s when her family was subject to a child protection investigation and she was required to leave the perpetrator in order to retain custody of her children. Her declared fears at the time did not engender interventions from agencies to keep her safe and her eventual brutal murder by her husband when she tried to leave, gives indisputable credence to those early fears. Whether her experience of agencies at that time influenced her future silence is not known.

37. The fact that the victim's only known contact was with health services in the intervening years, marks the significance of health agencies' role in early identification and intervention in

domestic abuse. In earlier years, far less was known about health indicators of domestic abuse and neither the GP not the Emergency Department would necessarily have been expected during those years to identify any of the victim's health concerns as being potentially caused by her experiences of abuse. Nonetheless, opportunities were missed, firstly by the GP practice to discuss with the victim, the circumstances behind her spasmodic alcohol misuse and periods of stress and secondly, with the Emergency Department to enable patients to speak privately with staff. However, it is unlikely that these would have affected the tragic eventual outcome.

38. It is clear from the little involvement that agencies had with the victim and her family, that this homicide could neither have been predicted nor prevented. Nonetheless, the nature of the homicide, together with the recent change in the law relating to coercive control, should strengthen Dudley Community Safety Partnership's resolve to build community awareness of the wide-ranging nature of domestic abuse so that victims, their families, friends and communities can more readily identify experiences as abuse and be confident to seek help when they need it.

LESSONS TO BE LEARNT & RECOMMENDATIONS

39. Whilst the victim and her husband had little contact with agencies in recent years, this domestic homicide review has identified a number of areas where adoption of good practice could promote a more effective response to victims of domestic violence and abuse. The learning from this review is not limited to the agencies that were directly involved but extends to all agencies where there may be contacts with victims of domestic violence and abuse.

40. Health agencies have a key role in the early identification and response to domestic abuse. This review has shown that the GP Practice remains both a trusted and universal service, ideally placed to recognise indicators of abuse and guide those experiencing domestic abuse into early help. The IRIS Programme has provided the critical evidence base for how primary care can most effectively be this conduit to safety and support.

Recommendation 1: Adoption of Primary Care Early Intervention Programme

Dudley Community Safety Partnership should work with Dudley Clinical Commissioning Group to promote the take-up of domestic abuse early intervention programmes, such as *IRIS*, across its GP practices.

41. Likewise, Emergency Departments are well placed to respond to those experiencing domestic abuse at the point of crisis but need to have the systems and protocols in place to be able to do this effectively, such as seeing patients displaying potential indicators of domestic abuse in private.

Recommendation 2: Meeting NICE Quality Standard on Domestic Violence and Abuse QS116

The Dudley Group NHS Foundation Trust should report to Dudley Community Safety Partnership on its progress to meet this quality standard on a regular basis until each are satisfied that the standard is met.

42. This review has considered how women experiencing domestic abuse will frequently misuse alcohol as a means to cope with the domestic abuse that they are experiencing. At the same time, alcohol is becoming known as a common feature in domestic abuse related deaths.

Recommendation 3: Raising Awareness of the Links between Alcohol Misuse and Domestic Abuse

Dudley Community Safety Partnership should explore how the links between alcohol misuse and domestic abuse can be promoted across agencies in Dudley to enable early identification of potential abuse and effective pathways for protection and support.

43. This review found that domestic violence and abuse is still commonly defined as physical violence and that controlling and coercive behaviour is rarely understood as domestic abuse by communities.

Recommendation 4: Raising Awareness of Coercive Control

Dudley Community Safety Partnership should raise awareness of coercive control amongst its communities and specifically target key messages to the family and friends of those experiencing abuse.