safe & sound

Dudley's Community Safety Partnership

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

1. INTRODUCTION.

1.1. Summary of the circumstances leading to the review

1. This report of a domestic homicide review examines agency responses and support given to the victim, a resident of Dudley, prior to her murder in December 2015.

2. In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed in the community and whether there were any known barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

3. The key purpose for undertaking a domestic homicide review is to enable lessons to be learned where a person is killed as a result of domestic violence, abuse or neglect. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

4. This domestic homicide review concerns the death of the victim, a 54 year old 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.

5. Unusually, the victim and her family had no recent contact with agencies, besides health, prior to the homicide. Therefore, beyond incorporating information known through criminal proceedings, this review has considered this contact with health agencies; wider information on the history of the victim's relationship with the perpetrator;[redacted] and information on domestic abuse in the perpetrator's previous relationships, including perceptions of family and friends wherever possible.

6. The review panel would like to express their condolences to the family who have each been invited to participate in the review. The review panel also wishes to thank all those who have contributed and assisted with this review.

1.2. Timescales

7. The decision to undertake a review was made on 13th January 2016. Scoping and securing of files was undertaken promptly following the notification of the death and it became apparent that the victim and her family had had little contact with agencies. The decision was therefore made to postpone the commencement of the review until criminal proceedings had concluded in July 2016 in anticipation of engagement with key witnesses in those proceedings. The review was concluded on 24th April 2017.

1.3. Confidentiality

8. This Overview Report has been anonymised and, where stated, redacted. The nomenclature, 'victim', has also been used in order to protect the anonymity of the victim and family concerned. Preferred practice would be for the affected 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.

9. Whilst the details of each review remain confidential, available only to participating professionals and their direct line management, the report has sought to extract sufficient detail from the victim's narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

2. TERMS OF REFERENCE

2.1. Methodology

10. Dudley Community Safety Partnership's Domestic Homicide Review Panel Core Group reviewed the circumstances of this death and recommended to the Chair of Dudley Community Safety Partnership that a review should be undertaken as the criteria set out in Section 9 of the Domestic Violence, Crime and Victims Act (2004) had been met.

11. The Chair of the Community Safety Partnership approved the recommendation and the Home Office was notified on 13th January 2016 of the decision to hold a domestic homicide review. It was acknowledged that the timescale to conclude the review would be dependent on the criminal processes.

12. All local agencies were notified of the death and were asked to examine their records to establish if they had been approached by or provided any services to the family and to secure records if there had been any involvement.

13. Arrangements were made to appoint an Independent Domestic Homicide Review Chair and Author, Paula Harding, and agree the make-up of the multi-agency review panel.

14. It was confirmed that no other local authority areas were involved and that the Community Safety Partnership had access to legal advice, if required.

15. The Terms of Reference were drawn up by the Independent Chair together with the review panel incorporating key lines of enquiry and specific questions for individual agencies where necessary.

16. The first review panel meeting took place in May 2016 in preparation for the conclusion of criminal proceedings in July and all agencies were asked to provide a chronology of their contacts with the victim and her family, so that work could be started on drawing up an integrated chronology to track the journey of the family through the available records.

17. The Senior Investigating Officer in charge of the criminal investigation from West Midlands Police attended the second panel meeting early in September and was able to provide detail on the findings of the criminal investigation and the conclusions of the court which have been incorporated into this review. At this second panel meeting, Individual Management Reviews (IMRs) were requested to be undertaken together with information reports from agencies with less involvement. Briefings were made available for IMR authors by the Independent Chair and taken up by The Dudley Group NHS Foundation Trust.

18. The third panel meeting in November heard the detail of the two IMRs that had been requested and reviewed the remaining information available. The Panel members were able to discuss the progress of the review reports and request further clarification and additional material, where needed. The quality assurance role performed by the panel of the IMR reports was implemented. All panel meetings were minuted and all actions agreed for the panel have been tracked and signed off.

19. The fourth panel meeting in February 2017 considered and agreed the draft Overview Report and the final Overview Report was presented to the Domestic Abuse Strategic Group and endorsed by the Community Safety Partnership on 24th April 2017 prior to submission to the Home Office.

2.2. Involvement of Family and Friends

20. The victim is survived by her mother, a son and daughter from her first marriage and two sons from her second marriage to the perpetrator. Her father died within months of his daughter's death.

21. Members of the family were each informed of the domestic homicide review taking place by letter, with Home Office and AAFDA explanatory leaflets and advice included. Initial letters were delivered by hand via the Police Family Liaison Officer. The family was advised that the Chair would contact them again as soon as the criminal proceedings had concluded when they would be invited to contribute to the review in whatever manner they might choose.

22. Further letters were delivered following the end of the criminal trial, when the review could commence in earnest. As it was known that the family was being approached by several media outlets, the Police Family Liaison Officers, who were still in contact with the family, were briefed by the Senior Investigating Officer to be able to provide more detail and reassurance on the difference between this request to engage from other requests that the family may be receiving. Further letters were delivered in February 2017 when the overview report had been drafted but no response was received from any family member and it was taken that they had

declined engagement. All family members will be notified before publication of the report and engagement and support will be offered again at this time.

23. The perpetrator was also informed of the domestic homicide review taking place by letter, delivered in liaison with the prison authorities concerned. No response was received by ourselves or the prison officer tasked with supporting the delivery of the letter. The perpetrator had committed suicide before any further contact could be made at the conclusion of the review.

24. The victim had a very close friend who remains close to the victim's two sons from her second marriage. The friend provided detailed information to the Independent Chair which offered a valuable insight into the life of the victim over the twenty-one years that they had been friends. This insight has been incorporated into the review.

25. During the criminal proceedings, it emerged that the perpetrator had subjected his former partner to severe domestic violence. His former partner had provided a lengthy statement to the police, detailing the extent of this abuse. With the assistance of the police, a letter was also written to her requesting that she engage with the review but no response was received.[1]

2.3. Independent Chair and Overview Author

26. The Independent Chair and Overview Author is Paula Harding, who has compiled the Overview Report, the Executive Summary and co-ordinated the integrated action plan. 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

[1] The police posted the letter on behalf of the review panel to ensure that the anonymity of the perpetrator's ex-partner, and the confidentiality of her address, was maintained.

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.

27. 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].

2.4. Members of the Review Panel

28. Multi-agency membership of this review panel was agreed by the Domestic Homicide Review Panel Core Group and ratified by the Independent Chair and consisted of senior managers and/or designated professionals from the key statutory agencies. The Panel members had not had any direct contact or management involvement with the family of the victim and they were not the authors of the Individual Management Review reports.

29. Black Country Women's Aid provided particular expertise on domestic violence and the 'victim's perspective' to the panel. Wider matters of diversity and equality were considered when agreeing panel membership but not considered directly relevant to membership of the panel.

30. 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

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

- 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)

31. As the review continued, the need for The Dudley Group NHS Foundation Trust to undertake a more detailed assessment of their involvement was identified. The Trust were invited to consider whether they would wish to be represented on the review panel but considered that regular communication with the Independent Chair would suffice.

2.5. Key Lines of Enquiry

32. 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?

33. 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?
- 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?

2.6. Time Period

34. 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; [redacted] and information on domestic abuse in the perpetrator's previous relationships will also be sought to inform the review. Any significant information which might come to light during the review outside the set timeframe, were to be agreed by the review panel for inclusion if determined to be of relevance

2.7. Individual Management Review Reports (IMRs)

35. An IMR and comprehensive chronology was requested from 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

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

37. Chronology and/or information reports were requested from:

- Dudley Children's Social Care
- Dudley Safe and Sound (Community Safety Partnership) in respect of public information and awareness raising undertaken on domestic abuse
- National Probation Service in respect of the pre-sentence report for the perpetrator. A summary of this information was provided verbally to the panel.
- 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.

2.8. Agencies without contact

38. The following agencies were contacted but confirmed that the family members had not been known to them, or in some instances the panel determined that information that was known about wider family members was not relevant to the review:
    - Aquarius, providing support in the area to those with gambling concerns
    - Black Country (formerly Sandwell) Women's Aid
    - Care Grow Live(CGL), providing substance misuse services in the area
    - Dudley Metropolitan Borough Council Adult Services
    - Dudley and Walsall Mental Health Trust
    - Staffordshire and West Midlands Community Rehabilitation Company
    - Victim Support, providing support to domestic violence victims considered to be of standard risk in the area
    - West Midlands Fire Service

2.9. The definition of domestic violence

39. The Government's definition of domestic violence, which sets the standard for agencies nationally was applied to this review:

> *"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*
> - *emotional*
>
> *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.*
> *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."*

40. The inclusion of controlling and coercive behavior within this most recent definition is particularly relevant to this review.

2.10. Parallel Reviews

41. Beyond criminal proceedings, the review panel was not made aware of any parallel proceedings. No inquest was held as the cause of death was deferred to the conclusions of the criminal case.

2.11. Equality and Diversity

42. The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. In particular it was considered that the victim's gender was relevant to the review as well as likely experiences of domestic abuse in pregnancy. Whilst alcohol misuse is a feature of this case, the nature of the mis-use did not appear to be of a level that would warrant consideration as a disability within the Equality Act, although analysis of the

response of professionals to alcohol mis-use in the context of domestic abuse is nevertheless considered fully in the review.

2.11. Dissemination

43. The following recipients have received a copy of this report:

- Black Country Women's Aid
- CGL (Change, Grow, Live)
- Dudley Clinical Commissioning Group
- Dudley Council for Voluntary Service
- Dudley Federation of Tenants and Residents Associations
- Dudley Group NHS Foundation Trust
- Dudley Metropolitan Borough Council
- Dudley and Walsall Mental Health Partnership NHS Trust
- National Probation Service
- Office of the Police and Crime Commissioner for the West Midlands
- Reducing Reoffending Partnership
- Staffordshire and West Midlands Community Rehabilitation Company
- West Midlands Fire Service
- West Midlands Police

3. BACKGROUND INFORMATION

3.1. The victim's family history

44. In order to protect the identity of the victim and the family, the following anonymized terms have been used throughout this report:

Designation	*Age at the time of the death*	*Residing with victim at time of death*
The victim: the victim	54	
The perpetrator: The victim's husband	56	Yes
Child 1 of The victim and former husband	31	No
Child 2 of The victim and former husband	30	No
Child 3 of The victim and perpetrator	25	Yes
Child 4 of The victim and perpetrator	22	Yes

45. The victim and her second husband, the perpetrator, had been married for 28 years and lived in a suburban home with their two grown-up sons in Dudley. They ran a small and successful family business.

3.2. The homicide

46. In the period leading up to the homicide, the couple had made a bet together about who could give up their respective addictions: the victim was to give up alcohol; the perpetrator was to give up gambling. The perpetrator went on to lose £11,000 by gambling, and after spending some time with friends, the victim came home seemingly to make preparations for ending the relationship.

47. That evening, the couple began to argue upstairs in their home. The perpetrator assaulted the victim, firstly by pulling a chunk of her hair out and then, most viciously, with a hammer chasing her downstairs. The victim pressed a panic alarm, which the perpetrator disarmed by inputting the code and proceeded to chase her into the garden where the victim picked up a solar light to attempt to defend herself, to no avail. The forensic post mortem revealed that the victim had received sixteen hammer blows to her head and crushing injuries to her ribs.

48. Whilst the perpetrator admitted his guilt to the murder, he said that he had been provoked and knew that his wife was going to leave him. The court decided to hold a 'Newton Hearing' as the defence and prosecution disputed the facts upon which the court was going to the

sentence the defendant.[3] The hearing in July 2016 sought to establish the factual basis for the sentence to be passed.

49. A pre-sentence report undertaken by the National Probation Service is said[4] to have advised the court that the perpetrator was grandiose, self-absorbed, lacked spontaneous empathy and blamed his wife and his sons for having made him feel like an outsider. The report concluded that he posed a significant risk of harm to any future partner, but not necessarily to other people.

50. 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 and went on to sentence him to a minimum sentence of 18 years, decreased by 3 years for his admission of guilt. The perpetrator would have been aged 72 when he would have been available for parole but rather, he committed suicide on the one year anniversary of the murder.

4. CHRONOLOGY

51. The sections below have been based on information provided from agency records and from interviews with staff; agencies' analysis in IMRs; information from the victim's friend; together with verbal summaries of the criminal trial and the pre-sentence report of the perpetrator. They represent the Independent Overview Author's view of significant information and events about the victim.

52. The victim and her second husband, the perpetrator, met 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 an affair, only to be discovered shortly afterwards by her first husband, who went on to divorce her.

53. The victim lost custody of the two children [redacted] in **1990**. Whilst the matter was being investigated, the victim alleged that the perpetrator had tried to strangle her for refusing to have sex with him. The brief records kept since those times indicate that the victim was asked to leave the perpetrator if she sought to maintain custody of her children. She reported being too afraid to leave him and in **1991**, custody was granted to her ex-husband. All charges

[3] Further explanation of a 'Newton hearing' can be found at http://www.cps.gov.uk/legal/l_to_o/newton_hearings/index.html

[4] The author of the pre-sentence report provided a verbal summary of the report findings to the domestic homicide review panel.

against the perpetrator were dropped and records are no longer available to explain why this was.

54. The couple went on to marry, to have two sons and to build up a successful business. The victim was described by her friend as having been the ideas and driving force behind the business which, from humble beginnings selling at car boots and market stalls, was built into the profitable business it remains today. The couple reportedly worked very hard and enjoyed a wealthy lifestyle and exotic holidays. It was on one of these holidays where they met the couple who became their closest friends of the last 21 years, one of whom participated in the review and who, in the absence of the family coming to the attention of agencies, has provided the most background to the family history.

55. In the intervening years there was little relevant contact between the family and agencies beyond routine health concerns, with the exception of the following:

56. In **October 2004**, the victim attended the Hospital Emergency Department with a head injury which needed sutures. Her explanation was having fallen whilst drunken although medical staff noted there was no evidence of alcohol consumption. The perpetrator attended with her and was verbally abusive to reception staff.

57. In **July 2006**, the victim told the primary care nurse that she was experiencing stress.

58. Between **March and May 2007**, she attended the GP practice three times through stress related concerns and, during this time, declared drinking seventy units of alcohol per week but by May consultation stated that the stress at home was getting better.

59. In **August 2007**, the perpetrator was arrested and charged with assault of a male.

60. In **June 2008**, the victim attended her GP with unexplained pain in her neck, shoulder, chest and back and in April 2009, she attended her GP with pains in the same area, allegedly this time from a car accident. In a **2010** consultation with the GP she reported feeling stressed due to driving in ice.

61. In **April 2012**, the perpetrator attended Accident and Emergency experienced a minor head injury reportedly having collapsed.

62. Between **August and September 2012**, the victim attended her GP with concerns over weight and excessive alcohol intake which she reported, by the September, as having managed to get under control.

63. In **August 2013**, she attended the GP practice for regular checks but again talking about stress and periodic increases in alcohol consumption.

64. In **October 2013**, the victim discussed general aches and pains and unexplained pains in her hips, calves and upper arm.

65. In **January 2014**, the victim attended the Hospital Emergency Department with an injury to her left ankle and foot explained by tripping on a step. Her husband attended hospital with her.

66. In **September 2014** she complained to her GP about pain under both ribs, without cold or flu symptoms, and with knee pain. From the examination it was noted, that she looked well.

67. The victim continued to attend her GP for regular health checks until her death in **December 2015.**

5. OVERVIEW & ANALYSIS

68. In view of the limited contact with agencies, the overview and analysis sections of this domestic homicide review have been combined to enable an easier narrative.

5.1. Known Domestic Abuse in the Early Relationship

69. Although, quite rightly, it would be beyond the scope of most domestic homicide reviews to provide a robust analysis of agency responses over twenty-five years ago, the couple's early relationship is worthy of attention.

70. 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 in the household. The domestic abuse had come to light during [redacted] allegations against the perpetrator. Whilst the investigation was going on, the victim herself alleged that the perpetrator had tried to strangle her for refusing to have sex with him.

71. From the sparse records that remain from this time, it is clear that the victim was asked by children's social care to end the relationship with the perpetrator in order to protect her children. It was recorded that she was frightened of the perpetrator but it was not recorded how the expression of her fears was responded to. Neither was it recorded whether support was offered to the victim to help her to end the relationship and offer practical solutions to do so, or indeed whether support was offered to help her consider the impact of the known domestic abuse upon herself and her children and thereby address the barriers to the family becoming safe. In the absence of this sort of support, the requirement to leave a relationship or be judged failing to protect your children, becomes an ultimatum which cannot be fulfilled.

72. The recent criminal investigation has revealed that the perpetrator's former relationship was indeed characterised by very serious domestic violence and abuse and his former partner had to go to elaborate lengths to flee her abuser, move across the country and change her name, for fear that she would be killed.

73. Likewise it is not recorded in these historic police and social care records why the allegations against the perpetrator did not lead to prosecution. On the other hand, the victim's accusations of assault and strangulation were unlikely to have been acted upon at the time, as they were within the context of the victim's refusal of marital sex. In 1990, rape within marriage was not yet illegal. [5]

74. Records of this time are understandably sparse and none of the staff who had been involved were available to interview. However, from the perpetrator's history of extreme domestic violence, from the records that exist and with our current understanding of domestic violence, it is possible to draw a picture of a woman with two young children who was frightened of a very violent man; a picture of a woman subjected to assault and possible sexual assault from her husband and of a woman required to give up her children to her ex-husband as she felt too unsafe to leave her husband. 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.

75. 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, with the two very young children of this marriage, to neighbours. Recent witness statements were taken from her relatives to this effect but there was no record of the victim 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.

76. The victim had told her closest friend and confidante, about the physical violence that she had endured in these early years of the relationship but she did not recount, nor had her friend observed during their 21 year friendship, any physical violence thereafter. On the contrary, the victim had explicitly told her friend that the perpetrator had not been physically violent to her since and that, as her sons grew up, he would not dare to physically assault her without their retaliation. Her sons also held this view where, in testimony to the criminal proceedings, they believed that there had been no physical violence in recent times as they were both now big enough to protect their mother from him: the perpetrator was tall and well-built whilst their mother was small and slightly built, appearing "half his size".

77. Much more is known now about how victims of domestic violence will need to minimise their experiences, both as coping strategies for themselves and as protective mechanisms from potentially unsafe external intervention. It is not known whether this was indeed a factor in this case.

[5] On 23.10.1991, the Law Lords overturned the notion that women consent to sexual intercourse on marriage and cannot retract that consent. See Regina v Regina (Rape : Marital Exemption) The Times, 24 October 1991:Cr.App.R.216.

5.2. Potential coercive control

78. The victim's friend described the family as having a good life and the victim as being a happy, loving, affectionate, sociable and 'bubbly' person who loved to socialise, to holiday, to shop and to meet up with friends and family. Likewise, she described the perpetrator as enjoying socialising and being very gregarious. However, she also identified that he was controlling of his family and jealous and possessive of the victim. He would commonly discourage the victim from seeing her family; had assaulted one member of her family and argued with others causing a family rift. He would never leave the victim's side, whether this was to attend the hairdresser or do the daily shop. The victim described his behaviour to her friend as being loving, caring and attentive and did not appear to be frightened of her husband or appear to mind this constant attention.

79. Criminal proceedings found that although the family appeared to be financially secure, it became evident that the perpetrator controlled the money in the household and gave a monthly allowance to his wife and sons. Likewise, the family business was indeed a family affair with each member actively involved, but the perpetrator had become very much in control there as well as at home.

80. Each of these factors could indicate a pattern of controlling behaviour consistent with coercive control: isolation from friends and family; possessiveness and jealousy; systematic monitoring of the victim's daily life; financial control and hyper-control over the household (Home Office, 2015). The extent to which this control was coercive is not known. However, when combined with an early history of physical violence and the perpetrator's history of domestic violence, there is every indication of a pattern of domestic violence and abuse, irrespective of the victim's assessment to her friend that the behaviour was a demonstration of love and care.

81. It is not uncommon for professionals and the general public alike not to identify coercive control as a form of domestic abuse. Indeed it has only emerged into governmental definitions of domestic abuse in 2012. It does not appear that the victim's friends or family identified coercive control or understood the perpetrator's behaviour in those terms, if indeed it was.

5.3. Economic dependency

82. As the family appeared to have a degree of financial security, the victim's economic circumstances were never known to any agency. However, testimony provided through the criminal case demonstrated the level of financial control that the perpetrator had over the family as a whole and over his wife in particular. The fact that the perpetrator provided a monthly allowance to his wife is important in the context of domestic abuse. On the one hand the failure to share responsibility for financial affairs and merely providing an allowance could

be seen as having the effect of infantilising his wife. Most significantly, research has defined this type of financial control as a means of maintaining a woman's economic dependency upon the relationship and in so doing creating a barrier to them leaving the relationship (Sharp-Jeffs, 2015). How far the victim perceived this potential economic dependency as a barrier to leaving the relationship is not known.

83. The murder enquiry found that the perpetrator's heavy gambling did not significantly impact on the family resources as the family business was successful.

5.4 Missed opportunities for enquiry in primary care

84. 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.

85. The IMR undertaken for the GP practice considered each of the presentations made by the victim and recognised that she had made no direct mention of abuse and found no information in the records concerning her relationship with the perpetrator. Staff involved in her care were no longer available for interview for further clarification.

86. This IMR considered that although the victim's health needs were being met and she was having regular check-ups, no consideration appeared to have been given to potential indicators of abuse. These indicators included regular accounts of stress; non-specific pain and variable alcohol intake.

87. There were three occasions in 2007 when the victim complained of feeling stressed. In one consultation she described this as stress at home and from family bereavement. Whilst she indicated in May of that year that the stresses at home were getting better, there is no evidence that any circumstances at home were being explored by the practitioner.

88. Concerns over stress continued in consultations in 2009, when stress levels were recorded as very high; in 2010 and again in August 2012. It is only at this last consultation that the GP has documented exploring social concerns and documenting that the victim was "…well, smiling and very chatty".

89. The victim made several visits to the GP related to muscular pain and documentation following those examinations did not record any bruising. Pain in her neck, shoulder, chest and back was unexplained in 2008 and was reported again in 2009, this latter time with a plausible explanation provided of having been involved in a car accident. In 2013, the victim complained of general aches and pains but no further enquiries were recorded as having been made by the GP to understand the context in which these were experienced.

90. The Royal College of General Practitioners posited the role of general practice in responding to domestic abuse as early as 1998 (Heath, 1998). Likewise, the potential role of all health professionals in identifying victims of domestic abuse through either universal or routine screening, was also proposed as early as 2000 (Department of Health, 2000). It would, however, be fair to say that it has been some years before the profile of domestic abuse has been raised sufficiently to change practice. For these reasons, it would not have been expected for the GP or practice staff to have routinely made direct enquiries of domestic abuse for many of the years that the victim was a patient, despite her presentation to what could now be seen to be indicators of abuse, as this level of enquiry was still only achieved by a minority of primary care practices.

91. In many ways, 'Identification and Referral to Improve Safety' (*IRIS*) programme[6] has provided an important impetus for changing primary care responses to abuse. *IRIS* is evidence–based programme of domestic abuse training, support and referral for general practice based staff and the clarity of the evidence provided of its benefits for both the patient and the primary care practice alike is proving to be a great catalyst for change. Whilst GPs are faced with growing demand and little consultation time to make in-depth inquiries into the nature of potential domestic abuse on top of presenting medical issues, the IRIS programme provides technological prompts to busy practitioners and reassuringly easy referral to a specialist on hand.

92. The *IRIS* guidance on domestic abuse is now promoted by the Royal College of Practitioners and it is reassuring to see that Dudley Clinical Commissioning Group, supported by the Community Safety Partnership, is set to adopt the *IRIS* programme within its area during 2017 and in so doing promote the early identification of domestic abuse in its primary care settings. Implementation of this proposal will help the Clinical Commissioning Group and its member practices to meet the quality standards expected of their services.

93. The National Institute for Health and Care Excellence (NICE) Quality Standard on Domestic Violence and Abuse requires that "People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion" (NICE, 2016, Quality Statement 116/1) and, "People experiencing domestic violence or abuse are offered referral to specialist services." (NICE, 2016, Quality Statement 116/3). Likewise, HM Government's Violence Against Women and Girls, National Statement of Expectations 2016, cites IRIS as one means in which expectations of a local area can be fulfilled in respect of placing " …the victim at the centre: Every victim, whether adult or child, is an individual with different experiences, reactions and needs. Local areas should ensure that services are flexible and responsive to the victim's experience and voice" (Home Office, 2016).

[6] Further information available at www.irisdomesticviolence.org.uk

5.5. Alcohol Misuse as a Potential Indicator of Domestic Abuse

94. Records of the victim's level of alcohol intake featured regularly over the years and there were periodic references to the victim's alcohol intake being significantly above the recommended weekly intake. Current government guidelines recommend no more than 14 units of alcohol per week on a regular basis (Department of Health, 2016). The victim was recorded as significantly exceeding these levels in 1998, 1999, 2001,2004, 2007, 2012,2013 and 2014 but also with regular intervals of low or nil intake. In 2007 her declared alcohol intake was 70 units per week which is five times the recommended limit.

95. Earlier in 2004, the GP practice was notified by the Hospital's Emergency Department of the victim having fallen when she was drunk and experiencing a head injury but this was not referred to in her routine health review two months later.

96. There is no evidence in the records, to suggest that the cause of her drinking was ever discussed with her, nor the triggers affecting the wide variation in her drinking over this time. Neither did the records show whether advice was being provided in how to lessen alcohol intake or whether details of supportive agencies were offered to her, although on occasion general health education was noted and this may indeed have included the relevant advice. In this sense, it is not known whether her direct medical needs were only being monitored rather than addressed or whether this was merely a recording issue.

97. The connection between domestic abuse and substance misuse is increasingly understood in the literature and studies consistently demonstrate a heightened prevalence of alcohol misuse for those experiencing domestic abuse. Although data in this area is not systematically collected, research has demonstrated that women experiencing domestic abuse are fifteen times more likely to use alcohol than non-abused women (Stark and Flitcraft, 1996; Humphreys et al, 2003). Explanations for this are often given whereby women experiencing domestic abuse turn to alcohol as a form of self-medication and relief from the pain, fear, isolation and guilt that are commonly associated with experiences of abuse. In a survey of domestic abuse services, "All survivors with problematic substance misuse…saw a link between their substance use and their experiences of domestic violence – the most commonly reported being to dull both the physical and emotional pain" (Humphreys et al, 2005:325)

98. Whilst significant work within discreet sectors responded to this early research through the promotion of alcohol and domestic abuse as overlapping issues, the requirement for early identification of domestic abuse, specifically through alcohol misuse, in primary care is a much newer expectation. For this reason, the GP practice would not have been expected to have identified the links between domestic abuse and alcohol misuse during many of the years of their involvement with the victim. However, the opportunity to enquire as to why alcohol use increased so markedly at different times and, alongside this, to enquire about the causes of the stress that the victim was reporting, or the context to the aches and pains that were often

without explanation, were clearly missed opportunities for the victim to disclose any abuse that she may have been experiencing, with the exception of an enquiry in 2012, when indeed no abuse was disclosed.

99. The aforementioned *IRIS* guidance on domestic abuse identifies substance misuse as an indicator of domestic abuse. It is also clear in its advice about the need to refer to alcohol services as well as domestic abuse services when both issues are present (University of Bristol,2011). In this way, Dudley Clinical Commissioning Group's plans to adopt the IRIS programme within its area during 2017 will undoubtedly help in the identification and response in primary care to those experiencing the overlapping issues of domestic abuse and alcohol misuse.

5.6. Missed opportunities for enquiry at Emergency Departments

100. The IMR completed by the Dudley Group NHS Trust analysed the victim's attendance at their Emergency Department. The Trust reviewed records since the victim's first attendance in 2004 when she presented with a head injury which needed sutures and overnight observation. Current understanding of domestic abuse would have expected staff to identify the inconsistencies in her explanation with her medical condition: she provided an explanation for her head injury as having fallen whilst drunk although medical staff noted that there was no evidence of alcohol consumption. Current understanding of domestic abuse would also have expected staff to recognise that the perpetrator's demeanour, having been verbally abusive to reception staff, warranted seeing the victim on her own and asking direct questions about domestic abuse. However, this event took place twelve years ago when understanding of domestic abuse and the requirements of staff were not as they are today.

101. The victim attended the Emergency Department a number of times in the intervening years with medical conditions wholly unrelated to domestic abuse. However, the Trust has 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.

102. Emergency Departments in the West Midlands are increasingly being alerted to a relationship between alcohol and domestic abuse from their activity in monitoring and sharing information on assault related injuries including information on alcohol consumption and domestic abuse.[7] As a result, alcohol consumption has become a known factor in at least 50

[7] This data submitted by participating Emergency Departments within the Injury Surveillance to Tackle Violence (ISTV) guidance, is added to data from Hospital Episode Statistics (HES - http://www.hscic.gov.uk/hes) and data from West Midlands Police on assault-related injuries to form the

per cent of cases where domestic abuse had been presented in this way, between 2013 and 2016 (Public Health England West Midlands, 2017).

103. The Trust has identified measures within its individual action plan to address this issue of non-compliance with important pieces of self-disclosed patient history.

104. The victim's next attendance with a physical injury was early in 2014, when she had injured her foot and ankle. Her explanation for the injury was that she had slipped off a step. For the purposes of this review, the Trust's Consultant Lead for Safeguarding Adults has reviewed the case and concluded that the injury was wholly consistent with the victim's explanation. It was recorded that the victim's husband was in attendance with her.

105. Emergency Departments share the same expectations to meet best practice contained in NICE Quality Standards on Domestic Violence and Abuse (NICE, 2016) as those identified for primary care in earlier sections (see paragraph 88 above). Particularly relevant is Quality Statement 1 which recognises that, "Some people who present to frontline health and social care practitioners have indicators of possible domestic violence or abuse. Services should ensure that they can provide a safe and private environment in which people feel able to disclose that they are experiencing domestic violence and abuse"[8].

106. Quality Statement 1 goes on to identify potential indicators of abuse including "traumatic injury, particularly if…. with vague or implausible explanations" (QS116, NICE, 2016) This foot and ankle injury in 2014 may indeed have been the result of an innocent stumble, a wholly plausible explanation, but the victim was discharged within 25 minutes and did not have an opportunity on her own to declare, or be safely asked, if circumstances were otherwise.

107. In recent years, the Trust has referred to the increased profile of domestic abuse in the organisation. A dedicated Health and Well-Being Nurse now works within the Emergency Department advising staff and signposting patients to sources of support where domestic abuse or alcohol may be a concern and Black Country Women's Aid is working with the hospital to explore how services could be improved for victims of domestic abuse, particularly in the Emergency Department and other Urgent Care points of access within the hospital.

108. At the same time, the Trust has strengthened the domestic abuse content in its safeguarding training at levels 1 and 2[9] . This action could satisfy NICE Quality Standard 2 on Domestic

'Violence Related Injuries Surveillance Workbook'. The workbook is produced monthly on behalf of West Midlands Violence Prevention Alliance by Public Health England West Midlands and it contains surveillance data and epidemiological summaries on violence-related injuries.

[8] Available online at https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse

[9] Levels of training required for safeguarding are defined in the Royal Colleges' Intercollegiate Document (2014) Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Available online at http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3).pdf

Violence and Abuse which encourages that, “People experiencing domestic violence and abuse receive a response from level 1 or 2 trained staff.” (NICE, 2016, QS116). It is also reviewing its Safeguarding Adult Training Policy for the same purpose and introducing a Level 3 training programme with a more in-depth emphasis on domestic abuse. Each of these developments feature in their individual action plan.

5.7. Community Awareness of Domestic Abuse

109. Coercive control may have been a feature of the couple’s relationship, yet no-one identified the observable behaviours as potential domestic abuse. Therefore, *Safe and Sound*, Dudley’s Community Safety Partnership, as the lead strategic body tasked with tackling domestic abuse in the Borough, was asked to provide details of its activities in promoting community awareness of domestic abuse in the area.

110. *Safe and Sound* provided details of the campaigns, press releases and conferences that have taken place in the Borough since 2007. Public awareness campaigns have taken place at least annually since 2007, with additional campaigns promoted at holiday times and alongside sporting fixtures since 2009. In between the campaigns, frequent press releases reinforced messages, variously targeting specific audiences; advertising new services or aligning messages to key events in the Borough.

111. Specific messages about coercive control began emerging in this public awareness during 2013 and an innovative community champion initiative began in 2015. The Dudley Community Champion Project, run by Black Country Women’s Aid, seeks to raise awareness in the community about domestic violence and abuse as well as engage with community about their experiences, involve the community in future service development and run a survivor’s group.

112. Black Country Women’s Aid have already involved 200 members of the public in awareness raising sessions with plans to target particular groups in the future such as breast-feeding groups, the Ramblers, local faith settings, shops and information points.

113. During 2016, West Midlands Police introduced a targeted campaign named Salon Saviours involving training hairdressers to be able to signpost women experiencing domestic abuse to relevant services. 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 may have had some influence. Likewise greater awareness for friends and relatives may also have had some influence. Future plans to re-launch this campaign and wider measures for raising awareness of domestic violence and abuse, particularly coercive control, are featured in the action plans.

6. LESSONS TO BE LEARNT & RECOMMENDATIONS

114. 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.

115. 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.

116. 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.

117. 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 and that women mis-using alcohol are therefore fifteen times more likely to have experienced domestic abuse than non-abused women (Stark and Flitcraft, 1996; Humphreys et al, 2003). At the same time, alcohol is becoming known as a common feature in domestic abuse related deaths. In a recent study of domestic homicide reviews, 38 per cent of the reviews featured victims with problematic alcohol use (Alcohol Concern and AVA, 2016).

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.

118. 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.

8. CONCLUSION

119. 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 which, by the victim's own testimony, continued into their early relationship.

120. Whilst not articulating them as coercive control, those close to the victim described many aspects of the perpetrator's behaviour in the intervening years as controlling. The perpetrator was possessive, jealous and monitored the victim's daily life through his constant presence. He controlled the household's money to such an extent that the victim was given a monthly allowance in the same way as her sons, seemingly infantilising his wife, and he took steps to isolate her from wider family. It is more than possible that the perpetrator's tight control over the family's finances created circumstances of economic dependency and created a barrier to his wife in leaving the relationship.

121. 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. Whilst the victim declared to her closest friend that she understood her husband's behaviour to symbolise his care for her and never appeared to be fearful of him, we do not know whether the victim had cause to minimise any of her experiences.

122. 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, if indeed the abuse continued as surmised.

123. 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.

124. 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.

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10. ACTION PLANS

Action Plans are available on request by contacting community.safety@dudley.gov.uk

End