



DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY:

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Executive Summary

1. Introduction

This Domestic Homicide Review (DHR) examines the circumstances around the death of Mrs X and the responses of agencies that had involvement with the victim and the perpetrator, Mr X. Mrs X was murdered at the family home on Monday 29 April 2013.

Mrs X's husband, Mr X was convicted of her murder and sentenced on 25 July 2013 to life imprisonment with minimum term of 18 years. The couple had been in a relationship for thirty years and married for the past ten years. They had two children. The family lived in a relatively affluent area of Newcastle upon Tyne; they had limited involvement with either statutory or third sector organisations and there was little indication to agencies of the history of domestic abuse that has become apparent through the process of the criminal trial and this Domestic Homicide Review.

2. The Review Process

Following initial investigation of the murder, Northumbria Police notified the Chair of Safe Newcastle for the case to be considered for a Domestic Homicide Review. The Chair confirmed with the Home Office that this case met the criteria set to establish a domestic homicide review.

The initial DHR panel meeting was held on 13 June 2013 and attended by agencies that potentially had contact with the victim and perpetrator.

The participating agencies were as follows:

- Northumbria Police
- Newcastle North and East Clinical Commissioning Group
- The Newcastle upon Tyne Hospitals NHS Foundation Trust
- Safeguarding Adults, Newcastle City Council
- Your Homes Newcastle
- Newcastle Gateshead Alliance (NHS)
- Relate Northumberland & Tyneside

- Wellbeing, Care and Learning, Newcastle City Council
- Safe Newcastle Unit, Newcastle City Council

From this panel meeting it was agreed that the first task was the preparation of chronologies of any involvement with the victim, Mrs X or the perpetrator Mr X. These chronologies were primarily focused on the time period from 1 January 2013 to 29 April 2013, the date of the murder, in line with terms of reference of the review that were agreed at this meeting.

The agencies required to complete Individual Management Reviews (IMRs) by 29 July 2013 ahead of the next panel meeting on 16 August 2013 were:

- Northumbria Police
- Newcastle North and East and Newcastle West Clinical Commissioning Groups
- Relate Northumberland & Tyneside

The third panel meeting was held on 7 November 2013 and initial IMRS were presented by Northumbria Police and Newcastle North and East CCG. It was agreed that the Relate IMR was to be prepared following the conclusion of the criminal trial because of their involvement in this. As a trial date had been set for 3 February 2014, the next panel meeting was set for 28 April 2014, allowing time for completion of the Relate IMR and preparation of a draft overview report.

The Criminal Trial concluded on 13 February 2014 with Mr X being found guilty of murder; he was sentenced to life imprisonment with a minimum term of 18 years.

The initial draft of the report was reviewed at the panel meeting on 28 April 2014, where the decision was taken to make contact with two friends of Mrs X to ascertain whether they would like to contribute to the review process. The panel also decided that it would be appropriate to seek an interview with the perpetrator.

Following these interviews being undertaken, the overview report was re-drafted to reflect information that was obtained. Subsequent panel meetings were held on 4 September and 16 October 2014 to finalize the report and agree the action plan.

The review has extended beyond the stipulated six-month timescale due to:

- awaiting the completion of the criminal trial, which delayed the completion of the Relate Northumberland and Tyneside IMR
- seeking information from additional interviews
- re-drafting of the overview report

The Safe Newcastle Unit sought and were granted a period of extension for completion of the review from the Home Office.

3. Terms of reference

The purpose of the Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

In order to achieve these outcomes, the panel agreed that the focus of the report should be on a number of specific areas of practice in relation to participating agencies:

1) A number of primary incidents were identified within agency chronologies as significant in the relationship between Mr A and Miss B. In relation to these incidents consideration was to be given to any contact the agencies had with those involved around the time of the incidents, including addressing the following questions:

- Were practitioners sensitive to the needs of the victim, perpetrator and children and knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns?
- Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for risk assessment and risk management in domestic violence cases (relating to victims, perpetrators or children) and were those assessments correctly used in this case?
- Did any concerns relating to the victim/perpetrator lead to wider referral/assessment of the family? If not, are there indications that they should have done so?
- Were there any concerns relating to the children? Did these lead to consideration of domestic violence issues? If not, are there indications that they should have done so?
- Did the agency have policies and procedures in place for dealing with concerns about domestic violence?
- Were these assessment tools, procedures and policies professionally accepted as being effective?
- Did the agency comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case?
- Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered. Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they sign-posted to other agencies? Was this information recorded and shared, where appropriate?
- Had the victim disclosed to anyone and if so, was the response appropriate? Had disclosures to family and/or friends been shared with agencies, and if so was the response appropriate?
- Was there any indication of the victim having been isolated by the alleged perpetrator, or being subject to coercive control, and could these factors have impacted upon her accessing services or disclosing to agencies?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?
- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators?
- Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were the services for the victim and perpetrator?
- To what degree could the homicide have been accurately predicted and prevented?

- As this case was not subject to the MARAC process consideration should be given as to whether it should have been instigated.

4. Key issues arising from the review

It became clear from the review process that little was known to agencies about Mrs X, Mr X or their children. There was no reported history of any physical violence in the relationship and Mrs X did not appear to be concerned about her own safety in her presentation to staff from the agencies with whom she came in contact in the months and weeks leading up to her murder. In the limited contacts that agencies had there were some indicators that Mr X had behaved in a controlling manner towards Mrs X.

A friend of Mrs X contacted the police expressing concern about Mrs X's welfare seventeen days before she was murdered and shared information with the police in relation to Mr X having smashed things in the home. Mrs X and Mr X attended an initial assessment session with Relate eleven days prior to the murder. In this session, information provided by Mrs X gave rise to concern that there were potential indicators of domestic abuse, particularly in relation to controlling behaviour by Mr X and further individual sessions were planned. Mrs X and Mr X attended an appointment with the GP the day after their appointment with Relate. This focused on assessing Mr X's physical and mental health and there was no disclosure of domestic abuse.

Information from the criminal trial and the DHR process, particularly from interviewing Mrs X's friend, suggests that there were indeed significant risk factors present. Mr X had behaved in a controlling manner for some years, isolating Mrs X from support, demonstrating some level of obsessive thinking, and he had threatened self-harm. Without doubt the most significant factor in relation to Mrs X's death was that she was planning to leave Mr X and he was aware of this.

5. Lessons to be learnt

The key lessons to be learnt from this Domestic Homicide Review are related to the hidden nature of domestic violence and abuse in this case.

- **Domestic homicides that are very difficult to predict due to the ‘hidden’ nature of the domestic violence and abuse, have similar features of jealousy and possessiveness as cases where information is known**

This Domestic Homicide Review has highlighted an area that has previously been addressed within research into domestic homicides – that there is a cohort of cases where little is known by agencies about the victim and perpetrator. In these cases it often appears to agencies that the homicide came “out of the blue”. This was highlighted in the “Homicide in Britain” study undertaken by the Dobashes in 2002.

Their research compared men with no previous convictions with men with at least one previous conviction prior to the murder. The groups *differed* in childhood and adulthood, with problematic lives and offending among the group with previous convictions and more “conventional” profiles among the group with no previous convictions but were *similar* in terms of circumstances at the murder and cognitions about the victim, especially possessiveness, jealousy, separation, empathy and remorse. The researchers argue from their findings that the similarities challenge the notion that the murder comes “out of the blue” and underscores the relevance of gender and a feminist analysis of domestic homicide.

Information provided by Ms A and from the criminal trial of Mr X highlights that possessiveness and jealousy were strong factors in this case and we are now aware that, prior to the murder, Mrs X had decided to end the relationship with Mr X. These factors were also evident in Mr X’s presentation when interviewed in the process of the review, when he presented as having little or no remorse or empathy.

- **Family and friends of victims will invariably hold more information about the detail of domestic violence than agencies**

There was very little information available to agencies and no strong indicators of high risk from the information they did obtain. This case again highlights the hidden nature of some cases of domestic violence, particularly in more affluent populations that are not traditionally 'policed' by social care and criminal justice agencies. Information from Mrs X's friend in the process of this review gave an insight into the dynamics of domestic abuse within the family. This reinforces the need for continuing domestic violence awareness-raising campaigns amongst the public and encouragement for friends and family members to report concerns. It also challenges agencies to respond positively to disclosure from friends or family members of potential victims.

- **Domestic violence is likely to be more 'hidden' in affluent areas**

Mrs X was evidently quite socially isolated. Middle class families tend on the whole to be more geographically mobile and thus distanced from wider family support. Evidently wider social networks were not strong and most people with whom Mrs X connected socially were reluctant to become involved in her life. It would appear that Mr X exploited and exacerbated these circumstances in seeking to exert control over Mrs X's life by making the family home an uncomfortable place to be.

6 Recommendations

The following recommendations are those agreed by the panel, as these relate to crosscutting issues affecting more than one agency.

- 1. Safe Newcastle to agree with partnership agencies, including schools, an approach to increasing community awareness about domestic violence abuse so that family and friends of victims know where to access appropriate advice and support.**

This is particularly important in relation to highlighting emotional abuse / controlling behaviour as being domestic violence and that help and support is available even if

the abuse has not been physical. This issue was highlighted in the Home Office publication, 'Domestic Homicide Reviews: Common Themes Identified as Lessons to be Learnt' (Home Office 2013). It has also been highlighted in the recent proposal to explore the possibility of a crime of 'domestic abuse' to address cases where there is a pattern of controlling behaviour but no physical assault.

- 2. All agencies to review their process for responding to concerns in relation to domestic violence and abuse expressed by family and friends to ensure that measures are in place for proactively responding to these and seeking further information whilst maintaining the confidentiality of the victim.**