



*THE CONTENT OF THIS REPORT IS RESTRICTED*

**DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT:**

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## **Preface**

This report of a domestic homicide review (DHR) examines agency responses and support given to the victim, Mrs X, a resident of Newcastle-upon-Tyne prior to the point of her death on Monday 29 April 2013. It also addresses agency involvement with her husband, Mr X, who has been convicted of her murder.

Mr X was convicted of murder and sentenced on 12 February 2014 to life imprisonment with a minimum term of 18 years. Mrs X and Mr X had been in a relationship for 30 years, and married for the 10 years prior to her death. They had two children, who now live with family members.

We would like to express our profound sympathy for family members of the victim and assure them that in undertaking this review we are seeking to learn lessons from this tragedy and to improve the response of organisations in cases of domestic violence.

This is the third Domestic Homicide Review to be carried out in Newcastle-upon-Tyne. Some changes in agency policy and practice have been implemented as a result of recommendations of the first review. The second review is ongoing currently.

We would like to thank all those who have given their time and co-operation through this review process as review panel members, Individual Management Review (IMR) authors and those staff members of participating organisations who were interviewed as part of the preparation of IMRs. We would also like to express gratitude to the Safe Newcastle Unit for administration support for the review process.

## **Introduction**

### **1.1 Domestic Homicide Review Process**

Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011.

It states that a Domestic Homicide Review will be undertaken following:

- The death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
- A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- A member of the same household as himself, held with a view to identifying the lessons to be learned from the death.

The purpose of the 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.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action should be initiated, the established agency disciplinary procedures should be undertaken separate to the DHR process. Alternatively, some DHRs may be conducted concurrently with, but separate to, disciplinary action.

As far as is possible, the review has been conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame.

The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

The review will also assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff.

## **1.2 Involvement of the victim's family**

Following the first Panel meeting the Chair, in liaison with Northumbria Police's family liaison officer, made initial contact by letter with Mrs X's father. Following on from this telephone contact was made to fully explain the purpose of the review, answer any questions he may have, and discuss with him whether he would like to participate in the review. Mrs X's father stated that to his knowledge his daughter had not had any contact with agencies but did mention that her friend had expressed concern to police and he felt this may be useful for the review. He went on to state that he himself did not wish to participate in the review but would like to be updated in writing and to have the opportunity to see the overview report once it is written. The Chair agreed to contact him again when the overview report was completed. Following the completion

of the draft report the Chair once more made contact with Mrs X's father advising him of the likely timescales for completion of the review and to discuss arrangements for him to have sight of the report.

The family liaison officer also identified that Mrs X's mother had been kept up to date regarding the police investigation by the father of Mrs X, although they are no longer in a relationship. This was due to the fact that Mrs X was diagnosed with dementia, which the Panel felt made it inappropriate to send a letter or telephone given that the extent of her dementia was unknown. Furthermore, the Panel decided that it was not appropriate to expect Mrs X's father to update her mother, particularly given that he himself did not wish to participate in the review process. Consideration was then given to contacting Mrs X's mother via victim support; however it emerged that she had declined contact with them. In light of this it was agreed that attempts would be made to contact Mrs X's mother, following completion of the final report, via Mr X's father. This was ongoing at the time of the completion of the report.

The Panel took the decision that it would be appropriate to interview Mrs X's friend, Ms A, who had previously contacted the police due to concerns in relation to Mrs X's welfare. This was in light of the very limited information that agencies held about the family. The interview with the SIO in the case did provide information from the trial witnesses in relation to the nature of Mr and Mrs X's relationship. However, it was felt that it would be beneficial to gain a fuller understanding. The interview with Ms A did indeed give a much fuller understanding of the history and dynamics in the family. Ms A also made comment in relation to some of the agencies that were involved with the family; these are outlined in the report.

Contact was also made with Mr Z, a friend of Mrs X with whom she had begun a personal relationship just prior to the murder. He stated that he did not wish to participate in the review.

### **Involvement of others**

The panel also took the decision that the overview report author and another panel member should interview the perpetrator, Mr X, to further inform the report, specifically in relation to agency responses.

## **1.3 Participants in the Review Process**

### **1.3.1 Independent Chair and Overview Report Author**

Kath Albiston – Director, i-to-i Training and Consultancy Ltd. (Independent Review Panel Chair)

Peter Grant – Associate trainer/consultant, i-to-i Training and Consultancy Ltd. (Overview report author)

The DHR process has been chaired by Kath Albiston, a qualified Probation Officer, who prior to leaving the Probation Service worked within a joint Police and Probation unit acting as Chair for Multi-Agency Public Protection (MAPP) meetings. Working independently as a consultant and trainer for seven years she has undertaken a variety of roles within the domestic violence and Safeguarding arena, working with statutory and voluntary sector agencies around the writing of risk assessment tools, policy and procedure, and the training and clinical supervision of staff. She has also undertaken service reviews and scoping exercises in relation to provision of domestic violence services. Alongside her involvement with Domestic Homicide Reviews, she also currently acts as an ‘expert witness’, writing domestic abuse risk and vulnerability assessments for public and private law cases.

Peter Grant has undertaken preparation of the DHR Overview report in consultation with Kath Albiston. He has worked as an associate on a number of projects in the area of domestic violence since 2008. He has a background of working since 1995 as a practitioner, consultant and trainer in the field of domestic violence, with a primary focus on work with male perpetrators and risk assessment. He has undertaken specialist risk assessments for Child Protection and private and public law family proceedings. He was previously a member of the Executive Committee of Respect, the UK membership association for domestic violence perpetrator programmes and associated support services for women and children. He is currently part of a team responsible for assessing domestic violence projects against the Respect Accreditation Standard and is an accredited Respect trainer.

### **1.3.2 DHR Panel members**

The review was initiated by Safe Newcastle and the DHR panel consisted of members of all organisations relevant to the case. None of the Review Panel members have had any direct involvement with the case and all are of senior standing within their respective organisations. The panel members are:

Cllr Linda Hobson – Deputy Cabinet Member for Community Safety and Regulation, Newcastle City Council

Vera Baird – Police & Crime Commissioner for Northumbria

John Douglas / Steve Barron – Detective Chief Inspectors, Northumbria Police

Dr Stephen Blades, GP Lead for Safeguarding Adults, Newcastle North and East Clinical Commissioning Group

Frances Blackburn – Head of Nursing, Freeman Hospital, The Newcastle upon Tyne Hospitals NHS Foundation Trust

Linda Gray – Safeguarding Adults Co-ordinator, Newcastle Safeguarding Adults

Sheila Breslin – Director of Corporate Services and Assistant Chief Executive, Your Homes Newcastle

Chris Piercy - Executive Director of Nursing, Patient Safety and Quality, Newcastle Gateshead Alliance

Nick Price - Chief Executive, Relate Northumberland & Tyneside

Karen Simmons, Service Manager Initial Contact, Referral & Assessment, Wellbeing, Care and Learning

Lesley Storey - Community Safety Specialist, Safe Newcastle Unit, Newcastle City Council

Robyn Thomas – Head of Community Safety, Safe Newcastle Unit, Newcastle City Council

### **1.3.3 Individual Management Reviews (IMRs)**

IMR reports were produced by the three organisations who had contact with Mrs X and Mr X within the timeframe being addressed in this review. IMR reports were based on

a review of all records, both paper and electronic, relating to the victim and the perpetrator. Interviews were also undertaken, where appropriate, with staff members who had contact with either the victim or the perpetrator within the period of time covered by the review. The production of the IMRs was undertaken by staff in the following posts:

**Northumbria Police** – Major Crime Review Advisor

**Newcastle North and East Clinical Commissioning Group** – GP Lead for Safeguarding Adults

**Relate Northumberland and Tyneside** – Chief Executive

None of the IMR authors had any prior knowledge of either the victim or perpetrators in this case, ensuring that they could take an independent stance in reviewing practice within their respective organisation. All reports were reviewed and approved internally within the agency by a senior member of staff for quality assurance.

The nature of agency involvement and sources of information (records, interviews and relevant policies and procedures) contributing to the production of the IMRs are detailed below:

### **Northumbria Police**

Northumbria Police serves a population of 1.5 million people and covers an area of more than 2,000 square miles in the North East of England, from the Scottish border down to County Durham and from the Pennines across to the North East coast. The force is split into six geographical area commands and supported by 13 specialist departments.

In order to complete the Individual Management Review for the police, the IMR author accessed all records held on the police computerised crime recording system. In this case there was only one previous incident reported at the address. There were no arrest records, domestic violence records or child concern records for the victim, perpetrator or their children until the incident that led to this review. The IMR author was initially unable to interview police officers involved in the case due to their

involvement in the criminal case. Following the completion of the criminal case, Northumbria Police did not feel that such interviews would be necessary in terms of providing any further information that could assist the review.

In addition to the information presented in the IMR, the Overview Report Writer interviewed the Senior Investigating Officer in the murder trial to obtain further information about the case, including that provided by prosecution witnesses in the case.

### **Newcastle North and East Clinical Commissioning Group**

Newcastle North and East Clinical Commissioning Group is a group of seventeen GP practices serving a population of 155,000 people in the north and east of Newcastle-upon-Tyne. The coming together of these GP practices is a result of the NHS reforms as described in the Health and Social Care Act 2012 which saw clinical commissioning groups take control of the planning, purchasing and delivery of the NHS services from April 2013.

In order to complete the IMR the author reviewed the medical records of Mrs X, Mr X and their two children. The IMR was prepared prior to the criminal trial; the author was unable to conduct any interviews with GPs due to their potential involvement of in the trial. However, the author did share the report with the GPs who provided further information by e-mail.

### **Relate Northumberland and Tyneside**

Relate Northumberland and Tyneside is an independent local charity and part of the national Relate Federation. They offer relationship counselling and training services.

In order to complete the IMR, the author undertook a review of case notes pertaining to the one appointment attended by Mrs X and Mr X. Following the completion of the criminal trial, he also interviewed the counsellor who conducted this appointment, and consulted with the clinical supervisor who was overseeing the work of this counsellor. Quality assurance was also provided through email contact with a Principal Consultant at Relate nationally.

#### **1.3.4 Information from other agencies**

Information was also provided by two other agencies and following initial enquiries it was decided by the Panel that there was no need for them to prepare a full IMR:

**Newcastle Hospitals Trust** – undertook an independent case review of Clinical notes held by the Trust. Only one contact was within the time frame of the DHR terms of reference; this was in relation to brief urgent care for one of the children. This was not deemed to be significant and had no relevance to the review. In the absence of permission to share information there appeared to be no grounds to disclose details of this contact.

The independent review of all records revealed no relevant or significant events, prior to the defined period, in relation to any history of domestic violence, the risk posed by the alleged perpetrator, or the vulnerability of the victim or the children.

**Primary school attended by the children** – The Panel Chair made contact with the head teacher about potentially joining the panel. The head teacher felt that she couldn't contribute anything to the review. She stated that the school had had no domestic violence or safeguarding concerns in respect of the children. Following information disclosed by a friend of Mrs X as part of this review process, further contact was made with the school to discuss whether they had any broader concerns about the children's behaviour. The head teacher described Mr and Mrs X's son as something of 'a loner', but said this was not sufficient to give cause for concern. She described Mr and Mrs X as having a 'relaxed' parenting style but that they attended all parents meetings as required. She reiterated that there was nothing that would have been seen as an indicator of problems or abuse within the family home.

#### **1.4 Details of parallel reviews/processes**

There have been no parallel reviews undertaken in relation to this case within any participating organisations, nor within other multi-agency arrangements.

## **1.5 DHR process and timescales for this review**

Following initial investigation of the murder, Northumbria Police notified the Chair of Safe Newcastle, Cllr Linda Hobson 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, as outlined at the start of this report.

Following the decision to hold a review, Kath Albiston and Peter Grant were appointed as Independent Panel Chair and Overview Report Author.

The initial DHR panel meeting was held on 13 June 2013. The key participating agencies were initially identified. From this meeting it was agreed that the initial task was the preparation of chronologies of any involvement with the victim, Mrs X or the perpetrator, Mr X. This was to gain an overview picture of agency involvement and in order to determine which agencies should prepare IMRs to contribute to this Overview report. Draft Terms of Reference as outlined in section 1.6 below were agreed at this initial panel meeting. These terms of reference, which address key issues relating to agency practice and how this relates to relevant policies and procedures, form the basis of this report.

The second panel meeting was held on 16 August 2013. The terms of reference were reviewed and updated and initial chronologies were reviewed. It became evident that there was limited agency involvement. The process was delayed at this point due to there not yet being a representative from Relate Northumberland and Tyneside following a change of Chief Executive.

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<sup>th</sup> April, 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 the information obtained. Subsequent panel meetings were held on 4<sup>th</sup> September and 16<sup>th</sup> 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, and the additional information that needed to be sought from friends of the family.

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

## **1.6 Scope and Terms of Reference for the Domestic Homicide Review**

The Domestic Homicide Review Panel agreed the following areas, which were specific to this case, for consideration within this Review:

- 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.

The primary period covered by the review is from 1 January 2013 to the date of the murder on 29 April 2013. An initial review of information held by agencies indicated there was no relevant agency involvement with any family members prior to 2013. However it was agreed that any relevant information outside of this period that came to light during this review should be included as appropriate.

## **1.7 Coroner's Inquiry**

The Coroner's Office was notified by the Chair that a Domestic Homicide Review taking place in relation to this case. No additional investigation took place as part of the Coroner's Inquiry due to Mr X having been convicted of his wife's murder.

## **1.8 Consent and Obtaining Confidential Information**

The Panel Chair wrote to the perpetrator, via his solicitor, requesting permission for disclosure of confidential records. No response was received within the period of time set for a reply, which was 28 days. Therefore the agencies were asked to consider whether the public interest in maintaining the duty of confidentiality owed to the individuals was outweighed by the public interest in the use and disclosure of confidential information, records and health records for the purpose of this review. All agencies concluded that there was an overriding public interest in favour of the provision of relevant information, records and health records in order to complete Individual Management Reviews. There was no confidential material that was relevant to the review that was withheld for legal reasons.

## **2 Background Information**

### **2.1 Details of victim and family**

Mrs X was originally from the Isle of Wight but had been living in Newcastle-upon-Tyne for some years. She was 50 years old at the time of her death. She and Mr X had been in a relationship for thirty years, having met at University. They married ten years prior to her death, and had two children, a ten year old boy and an eight year old girl. The children are now living with family members in the North-East of England.

### **2.2 Relationships between victim, perpetrator and children**

Participating agencies had very limited contact with Mrs and Mr X prior to the date of Mrs X's murder. Most of what we know about their relationship has come from the interview with Mrs X's friend, Ms A, and from the SIO in the police investigation.

Ms A and Mrs X's children attended the same primary school and Ms A stated that Mrs X had confided in her over a number of years about the difficulties she was experiencing in her relationship with Mr X. She described a long history of Mr X controlling Mrs X's life and choices. She recounted that Mr X would demean Mrs X in front of other people, and generally put her down to destroy her self-confidence. She described the family home as being barely habitable, with Mr X promising to fix up the fabric of the house but never getting round to it. For some months there was a hole in the kitchen floor. When the children were very young they had no cooker or running water for some weeks. Mrs A's perception was that Mr X was deliberately isolating Mrs X and the children from others by making the house an unwelcoming environment, both physically and socially. Mr X ran an IT business from the family home but it would appear that this was failing and placing a financial strain on the family. These descriptions of the family home and Mr X's business were confirmed in the interview with the SIO in the criminal case.

Ms A was not aware that Mr X had ever used physical violence against Mrs X but she was aware that he had often lost his temper with the children. There was an occasion when he had grabbed and shaken his son and then pulled his pants down and smacked his son on his bare bottom; this was in response to him feeling that his son was not practicing his violin properly. Ms A said that Mrs X's son presented as a child

who had behavioural issues, including fighting and lashing out with other children. Ms A made an anonymous call to the NSPCC in April 2013 after an incident when Mr X had banged his head on the car bonnet. This incident, which was witnessed by the children, is outlined later in the report. Ms A did not however follow through the initial call to the NSPCC, as she was concerned that Mrs X might distance herself from the support that she was offering.

Ms A was aware from speaking to Mrs X that Mr X had smashed things in the house, including breaking the staircase bannister and smashing his guitar. He had also made threats to kill himself.

Mrs and Mr X lived in a relatively affluent area of Newcastle upon Tyne. Ms A commented that Mrs X was trying to give the appearance to the outside world that she had a 'normal' middle class family life but that the reality was far from this. Ms A said that many people were aware of the problems in the relationship but that most people commented that they felt it was 'none of their business' and many distanced themselves from the family. Ms A said that, on one occasion when she met with Mrs X in December 2012, she named Mr X's behaviour as being domestic abuse. Mrs X stopped having contact with her after this until March 2013, when she acknowledged that Ms A had been right, that she was experiencing domestic abuse. She said that she intended to seek legal advice about separating. Indeed, Mrs X had been to see a solicitor in the week before her death to commence divorce proceedings. Mr X was aware of this and very unhappy about the situation. Mrs X had also recently formed a friendship with another male, Mr Z, which would appear to have developed significantly in the weeks prior to her murder. It would not appear that Mr X was aware of this relationship until the day of the murder.

Mr X was very guarded in the interview that was undertaken with him as part of this review. He insisted that, as far as he was concerned, there had been nothing wrong in his relationship with Mrs X until the two weeks prior to the murder. He did not refer to the murder but he stated his view that Mrs X had been influenced in her thinking by a friend to whom he did not refer by name. Presumably he was referring to Ms A as he mentioned that she had called the police. He frequently blamed her for causing problems for his and Mrs X's relationship. He also said that he believed that Mrs X's

behaviour towards him might have been hormonal. He did not make any expressions of remorse, either in relation to Mrs X's death, or his children's loss of their mother. His only referral to the children was that they were currently being deprived of contact with him. Overall, his presentation in the interview reinforced the description provided by Ms A and confirmed by the SIO, that Mr X was self-obsessed and lacking empathy. His presentation fitted with the interviewers' experience of working with men who use coercive control in their relationships, and seeking to locate blame with others and with life circumstances.

### **2.3 History of domestic violence in the relationship and agency involvement from 1 January 2013 to 29 April 2013 (date of the murder)**

9 April 2013 – Mrs X had a telephone consultation with Dr D and was prescribed antibiotics for a chest infection. There was no mention of domestic violence or any associated factors in this records.

12 April 2013 – Information from the Senior Investigating Officer revealed that there was a verbal altercation between Mr X and Mrs X in the street outside a hairdresser shop, where Mrs X had taken her children in her car. Mr X had followed them by foot and after the argument had bashed his head against the car. Mrs X had later contacted her female friend, Ms A, by text message to say that she really needed to see her because "it had all really hit the fan" that morning and Mr X had said that he wanted her to move out of the family home. Ms A subsequently contacted the police having become concerned for Mrs X's safety as she could not get back in contact with her by text or telephone call. She informed police that Mrs X had contacted her earlier in the day stating that Mr X wanted her to move out. Ms A went on to state that Mrs X had told her that Mr X had been violent in the past, although not directly to her; however when he got angry he would punch walls and break things. Ms A was informed that an officer would ring her back with an update. Ms A was not aware of the incident that had taken place outside the hairdressers at that time so the police officers were not aware of any specific incident that had occurred that day.

Two Police Officers attended Mrs X's home address and spoke to her but did not enter the property. Mrs X stated that she was fit and well and, according to the police officers, appeared surprised that they had been asked to attend. The officers informed Mrs X that a friend of hers, Ms A, had raised the concerns. Mrs X stated that she would speak to her friend and let her know she was fit and well. The officers made checks regarding any previous police reports to the address and were informed there were none. Ms X was not displaying any signs of injury or distress and as a result no further action was taken. The officers made contact with Ms A to confirm that they had seen Mrs X, that she was fine and that she was going to call her. Ms A confirmed that Mrs X contacted her later that day.

This was the only incident of police involvement prior to the murder. Neither Mr X nor the children were seen by the police during this incident. Retrospective information from Ms A confirms that Mr X and the children were in the house at the time when the police called. She also said that Mrs X had told her subsequently that Mr X had blood on his head from a cut sustained when he bashed his head on the car bonnet. He had refused to seek medical help for the injury despite Mrs X asking him to. Ms A said that Mrs X had said that she felt that she could not let the police into the home because of the poor state of the house and that Mr X had blood on his head from the injury sustained from banging his head on the car bonnet.

15 April 2013 – Mrs X contacted Relate by telephone to arrange an initial appointment.

18 April 2013 – Mrs X and Mr X attended the initial appointment with Relate. This was purely an assessment session and no counselling was undertaken. This was a joint appointment in which Mrs X and Mr X completed separate 'Client Before Service' forms. On the basis of information contained within these assessment forms, the Counsellors' notes, and consideration of Relate's Internal Practice following the consultation, the decision was taken that further individual assessment sessions with both parties would be the next step. It is standard practice in Relate that, where there are any concerns about potential or actual domestic abuse, couples are seen separately. In this case, they had concerns about potential domestic abuse. Relate also suggested that Mr X should see his GP about a possible referral for psychological counselling.

Following the initial appointment Mr and Mrs X were told to await contact from Relate in relation to a further appointment. No appointment became available prior to Mrs X's murder, which was eleven days later.

19 April 2013 – Mr X attended a GP appointment with Dr C; he was accompanied by his wife, Mrs X. This appointment lasted for 37 minutes, around three times as long as a standard GP consultation. Mr X reported being depressed and anxious. He had a number of concerns about his physical health and was also concerned that he might have Aspergers Syndrome. He reported that these concerns were leading to marital problems. The severity of his depression was assessed using a standard patient health care tool approved for use by General Practitioners and this indicated severe depression. Mr X did not report any self-harm thoughts. His blood pressure was elevated.

Dr C arranged for him to have blood tests, a chest x-ray and an assessment of his breathing. These were done the following week and he had a follow up appointment arranged for 29 April 2013.

In view of the depression Mr X was referred to a Primary Care Mental Health worker within Newcastle Psychological Services.

Dr C reported in an e-mail to the IMR author for the CCG that at no point during the consultation on 19 April 2013 did Mrs X appear distressed or threatened. Indeed, he commented that she appeared concerned for Mr X's welfare. Dr C was left with the impression that the cause of their marital disharmony was Mr X's preoccupation with his health and his inability to discuss this with his wife.

Dr C had a telephone conversation with Mrs X approximately a week before her death when she phoned to check when Mr X's mental health appointment would be. At that point she did not appear concerned for her safety and Mr X was not with her at the time.

25 April 2013 – Mrs X saw Dr B in relation to sinusitis and was prescribed a further course of antibiotics. Again there was no mention of any factors linked to domestic violence in the record of this consultation. This was also the case from a review of all Mrs X's medical records.

29 April 2013 – Date of Mrs X's murder.

At around 11am Mr X attended at his Doctors Surgery and stated to staff that he had "hit" his wife and that she was lying on the floor injured. Staff contacted police and officers attended both the surgery and his home address, which is about 200yds away.

During this time Mr X stated to surgery staff that he had hit his wife, but then went on to say that she had fallen on a knife. At 11.08am officers arrived at the home address and entered the insecure house where they found Mrs X's body in the front downstairs room. The officers noted that she had what appeared to be a stab wound to her stomach and that there was a large amount of blood on the floor. They attempted to give CPR until an ambulance crew arrived, who took over for a brief period before pronouncing life extinct.

Officers who attended the surgery arrested Mr X on suspicion of Wounding with Intent to cause Grievous Bodily Harm. The scene was secured and the Senior Investigating Officer attended and arranged subsequent examinations of the scene by Scientists and a Home Office Pathologist to provide an interpretation of events.

Mr X was taken to the Police station where he was subsequently arrested for Murder. He was examined by a Forensic Medical Examiner who at first stated he would need an appropriate adult for interview, and then stated that he would need to be examined by a Forensic Psychiatrist. This duly happened later that evening, and the Psychiatrist stated that Mr X had no significant mental issues and was fit for interview with an appropriate adult.

### 3 Analysis of Independent Management Reviews (IMRs)

In this section of the report the individual management reviews completed by the key organisations participating in this review are considered in relation to the terms of reference as set out in the introduction of the report. This analysis addresses agency responses to key incidents prior to the homicide and the questions posed by the panel in relation to policy and practice of individual agencies and how agencies worked together. Where appropriate, the analysis addresses agency responses in light of information provided by Mrs X's friend, Ms A. We felt that this was important given how little information agencies held about the family and that Ms A has provided some insight into the history and dynamics of the relationship between Mrs X and Mr X. This analysis does not address agency involvement on the date of the homicide.

- **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?**

The police officers who attended to see Mrs X at her home address on 12 April 2013 followed police procedures in ascertaining her welfare and making appropriate checks in relation to any domestic violence history. These checks undertaken in relation to Mrs X, Mr X, the children, and the home address indicated that there was no reported history of domestic violence or incidents of any kind. The friend who reported the concern for welfare did state during the initial call that Mr X was controlling and had been aggressive in the past. However when Mrs X was spoken to she did not disclose any behaviour that gave cause of concern for her safety. In the absence of interviews with the officers attending this incident, their views and feelings regarding Mrs X's demeanour and attitude, and the basis of their decision not to gain entry to the property to carry out checks, cannot be gained or commented upon. The panel considered whether this information needed to be sought from the officers involved but felt that, given the length of time since the incident and that it did not have particular significance at the time, it was unlikely that there would be any meaningful benefit of undertaking this enquiry.

Police procedures in relation to welfare checks provide guidance that officers can gain entry to a home if they are concerned that there may be a threat to life, some indication of injury, or a breach of the peace taking place at that moment. In this case, none of these circumstances were present. In light of this, the panel concluded that the action taken by the officers attending was reasonable. However, it was also the view of the panel that the officers could reasonably have asked to enter the property, acknowledging though that had they done so the outcome may not have been any different.

As a result of the situation outlined above, the police had no contact with Mr X prior to the day of the murder. Neither did they have any contact with the children. Information from Ms A and from the criminal trial indicates that, had officers entered the family home and seen the dishevelled state of the home and Mr X having a visible injury to his head, the likelihood is that concerns would have been raised in relation to the welfare of the children and that further enquiries would have been undertaken.

Relate Northumberland and Tyneside had only one contact with Mrs X and Mr X on 18 April 2013. They both attended an initial assessment session, where they completed separate 'Client Before Service' forms. This is standard practice within Relate services, in order to help practitioners assess for appropriate services. As a result of this initial assessment, and following consultation with Relate's Internal Practice Helpline, the decision was taken to offer separate interventions. There is an observation that there was no direct disclosure of domestic violence, but there was "at least an indication of the victim having been subject to coercive control". The IMR author makes it clear that there was sufficient evidence present in information disclosed to consider that there were "strong contra indicators against couple work". Therefore, the Relate practitioner considered that there was the possibility of domestic abuse being present in the relationship. There was no suggestion at any point that there had been any use of physical violence. In light of the concerns about potential domestic abuse raised in the initial assessment undertaken by Relate, they offered Mrs and Mr X 'Individual Structured Interviews' as a next step. This was in order to gain a fuller understanding of possible abuse taking place within the relationship. This is standard practice within

Relate services where there are identified concerns in relation to potential domestic violence or abuse.

At the outset of the initial assessment session with Relate all couples are informed that, if any disclosures are made during the course of the session indicating the need for subsequent individual sessions, then such sessions would follow. Mrs X made disclosures during this initial session that Mr X had proposed use of a 'locator' phone application and of the incident in which he banged his head off the car bonnet. She also disclosed that Mr X had made threats of self-harm. In light of these disclosures the couple were advised that the next stage of intervention would be individual sessions. They were told that their names would be added to the waiting list and they would be informed when suitable appointments became available. No signposting to other agencies for support was offered to Mrs X because Relate's policy is that they will not offer further advice in a session where the partner is present.

There was no further contact with Relate from either Mrs X or Mr X after this initial appointment and they had no contact with the children.

The family GP practice had four separate contacts with Mrs X, two of these telephone contacts on 9 April 2013 and a week before the homicide. The first of these was in relation to her own physical health and the second to check when her husband's mental health appointment was likely to be arranged. She also attended an appointment in relation to her own physical health on 25 April 2013.

The most substantive contact with the GP was the appointment when Mrs X attended along with Mr X on 19 April 2013. In none of these contacts was there any information to suggest that Mrs X was a victim of domestic violence or abuse or that she was at risk. Whilst it was evident that Mr X was experiencing difficulty in relation to his mental health, there was no indication that he was a potential perpetrator of domestic violence. The consultation on 19 April lasted for 37 minutes, more than three times the length of an average GP consultation. Mrs X was present throughout and the GP noted that she presented as concerned about her husband and not in any way threatened.

It is difficult to comment on the level of knowledge of the GPs in relation to indicators of domestic violence, as it was never identified as a presenting issue. There is no documented discussion in GP records of the detail of marital problems being faced by Mrs and Mr X and whether this included any domestic violence or abuse. The consultation with Mr X was very comprehensive and considerable time was given to ensure this. In the circumstances and given Mr X's presenting problems, it is reasonable that the issues of domestic violence and abuse were not specifically discussed. The GP commented that Mrs X was present throughout the consultation and that she appeared supportive of her husband.

The subsequent telephone conversation between Dr C and Mrs X and her appointment with Dr B on 25 April 2013 also raised no concerns and on these occasions the couple were not together so there was a potential opportunity to make a disclosure. It would have been good practice for the telephone conversation following up on the consultation on 19 April 2013 to have been documented.

Ms A described Mrs X being subjected to controlling behaviour over a number of years and fearful of Mr X's reactions at times. Mrs X presented to the GP as being concerned about Mr X's welfare. This is borne out by information from Ms A, who stated that Mrs X was genuinely concerned for Mr X's welfare but she also described a pattern having been established of Mrs X feeling the need to take responsibility for managing the difficulties in their relationship and presenting them as being a 'normal' family to the outside world. In light of this presentation and the limited contact that professionals had with Mrs X and Mr X it would have been difficult for them to pick up on the dynamics of power and control in the relationship.

- **Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?**

All Officers within Northumbria Police receive comprehensive training in relation to dealing with incidents of domestic violence during their basic training and further input is received when there is a change to policy or procedures. They therefore should be knowledgeable about the potential indicators of domestic abuse and aware of what to

do if they have concerns about a victim or perpetrator. During a previous Domestic Homicide Review carried out by Northumbria Police in late 2012/early 2013 it was recognised that there was a gap in the training received by frontline staff and a training package was delivered in February and March 2013. This focussed on recognising and recording risk, and investigating offences particularly when the victim is not engaging. In this case, officers followed force policy and procedures in the one incident with which they were involved. In hindsight it is very regrettable that they did not enter the family home when ascertaining her wellbeing. Given the disclosure of previous domestic abuse by Ms A to the police when expressing her concern for Mrs X's welfare, perhaps they should have requested that they come in the house. As previously commented, at the time there did not appear to be sufficient concern to justify what the officers may have considered to be invasive actions in requesting to enter the family home.

All Relate practitioners receive domestic violence and abuse awareness and safety training. The IMR author confirmed that the practitioners involved in this case were up to date with all aspects of domestic violence training. They evidently followed Relate policy and procedures in offering individual sessions for proposed ongoing intervention.

The IMR author has confirmed that the GPs who had contact with Mrs X and Mr X had not received relevant training in relation to domestic violence and abuse. However, given Mrs X's supportive and concerned presentation in relation to her husband and the nature of GP involvement with them being on his physical and mental health issues, it is unlikely that training would have had any impact in any identification of domestic violence indicators.

- **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?**

Northumbria Police has in place policies and procedures for risk assessment and risk management in domestic violence cases. In 2008 Northumbria Police adopted the Multi Agency Risk Assessment Conference (MARAC) model and in April 2013 moved to the full DASH model for risk assessment, the national model accredited by the voluntary organisation Co-ordinated Action Against Domestic Abuse (CAADA).

Training was rolled out force wide in March 2013 ahead of the implementation of the DASH model. This procedure is available to all officers and staff via the force intranet and clearly defines the responsibilities of all officers and staff when dealing with cases of domestic abuse.

In relation to the incident on 12 April, when police officers attended and spoke to Mrs X the concerns reported by her friend, there was no specific incident of domestic violence reported and Ms A's concerns about Mrs X's safety appeared to be unfounded. In light of this information and the absence of any intelligence in relation to domestic violence, in accordance with police force policy no referrals or risk assessments were undertaken. As a result of this and previous DHRs, Northumbria Police have sought to address where there are inconsistencies between third party reports and the presentation of the victim at the scene. Procedures have been amended to require officers to revisit the third party to clarify information provided. In light of this case, consideration needs to be given to extending this procedure to concerns for welfare where there is some indication from third party reports of domestic abuse.

Relate has a Domestic Violence and Abuse policy and procedures that address assessing and consulting cases where domestic violence is a feature. The Relate practitioner undertook a standard initial assessment with Mrs and Mr X following these nationally approved procedures. This included screening for potential domestic violence and abuse. The outcome of the assessment was that there was sufficient concern in relation to coercive control from Mr X to Mrs X to warrant the decision not to offer couple work. This decision was undertaken following telephone discussion with a national senior practitioner, following Relate procedures.

As a result of the initial assessment, the Relate Practitioner also suggested that Mr X see his GP about possible referral for psychological assessment. This was following Mr X's disclosure that he had conducted an online self-assessment for Asperger's Syndrome and because of his disclosed anxiety. Mr X contacted his GP the following day, 19 April 2013, and he and his wife attended this appointment later that day.

There was no indication to the GP practice that domestic violence was an issue in the relationship. Therefore no domestic violence policies and procedures were followed and no domestic violence risk assessment was undertaken. As the IMR author was unable to interview the GPs, it has not been possible to ascertain what policies and procedures exist and how they would have responded in the event of domestic violence being disclosed.

- **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?**

Contact of agencies with Mrs X, Mr X and the children prior to the date of the murder was very limited. As outlined already in the report, these contacts did not raise significant concerns in relation to the safety of Mrs X or the children.

As the incident involving the police was dealt with as a concern for welfare, there was no ongoing intervention nor referrals made.

Relate's intervention was limited to one initial assessment appointment. Whilst there were concerns raised, these appear to have been tentative and not at a level to warrant information sharing with other agencies. However, the guidance received from the Relate helpline confirmed that further individual assessment sessions with both parents would be the next appropriate step.

Mr and Mrs X were placed on the Relate waiting list for further appointments. Eleven days later they were taken off the waiting list when the incident was reported in the local news. In the intervening period no suitable appointment had become available as there was a waiting time of a few weeks at that point. As already noted, there was no contact with Relate from either Mr or Mrs X following the initial appointment.

From consideration of this case Relate will review their procedures in relation to enabling earlier follow-up contact with potential victims where initial disclosure of domestic abuse or violence is made and there is some waiting time before the next allocated appointment.

Mr X's GP did undertake a comprehensive assessment in relation to his presenting problems at the appointment on 19 April 2013. This assessment addressed the severity of his depression and his suicide risk was considered. The assessment indicated that Mr X was suffering from severe depression. He made no report of thoughts of self-harm.

As a result of the assessment of Mr X's mental health undertaken on 19 April 2013, Dr C agreed to make a referral to a Primary Care Mental Health Worker from within Newcastle Psychological Services in order to provide treatment of his depression.

- **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?**

It was established at the start of the review process that neither child was known to Children's Services. In the process of the review, contact was made with the head teacher of the school attended by both children. The head teacher reported that there were no domestic violence or safeguarding concerns in relation to the children. She spoke of the son being a 'loner' and the parents not really seeing this as a problem but she said there was nothing concerning within his behaviour and the parents attended all family meetings within the school. She commented that they had a relaxed style of parenting but that there was nothing that gave cause for concern. There is no reference to the children within the contact that the police and GPs had with Mrs X and Mr X. Both agencies also note in their IMRs that there were no recorded concerns in relation to the children.

Relate identified concerns regarding the children in relation to the disclosure made in the initial session that they had witnessed the incident of Mr X banging his head on the car. They considered that this behaviour, whilst not targeted directly at the children, would likely have a detrimental impact and that this would need to be addressed in the individual sessions with Mr and Mrs X. The Relate IMR author considered that this limited information and that they were surmising the impact on the children did not raise sufficient concerns for Relate to have made a child protection referral. Relate were

intending to carry out further assessment within subsequent individual sessions. This would have included consideration of the impact of any abusive behaviour on the children.

Ms A expressed the view that Mr and Mrs X's ten year old son had behavioural problems characterized by fighting and lashing out. She said that he had been assessed for autism – the assessment concluded that he was not autistic. Ms A was clear in her view that his behaviour was directly linked to the home environment. Enquiries via the family GP have no record of this assessment but suggest that this is likely to have been done through the Newcastle Educational Psychology Service.

The panel considered whether interviews with the children should be undertaken as part of this review. It was concluded that, given their young age it would be inappropriate to undertake this. It was felt that any benefit of speaking to them would likely be outweighed by the potential detrimental impact upon them.

- **Did the agency have policies and procedures in place for dealing with concerns about domestic violence?**

Both Northumbria Police and Relate have comprehensive domestic violence policies and procedures that were followed in this case. Many GP practices do not have domestic violence policies and procedures but work is underway to implement standard policies and procedures within the Newcastle North and East Clinical Commissioning Group. This work has been undertaken in response to previous Domestic Homicide Reviews.

- **Were these assessment tools, procedures and policies professionally accepted as being effective?**

Domestic violence procedures were followed by the police and Relate within the limited contact that they had with Mrs X and Mr X.

Northumbria Police had only one contact with Mrs X, resulting in a recording of concern for welfare with no further action, and no contacts with Mr X or the children before 29 April 2013. There were therefore no opportunities for them to make any assessments

or decisions regarding domestic violence and consequently there were no risk management plans put in place.

Relate's assessment process used in this case indicated some concern in relation to potential domestic abuse and they rightly offered further work on an individual basis to both Mrs X and Mr X. This was in line with national Relate procedures in relation to potential disclosures of domestic abuse.

- **Did the agency comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?**

There was no multi-agency working in this case. This was because of the limited contact that agencies had with the family and that no significant concerns in relation to domestic violence or abuse were identified from these contacts.

The GP practice did commence the process of referring Mr X into appropriate mental health services. However, given the timescale with the consultation being only ten days prior to the date of the murder, he was not seen by the mental health services to which he had been referred.

- **What were the key points or opportunities for assessment and decision making in this case?**

Other than the assessments undertaken by the police, Relate and the GP practice, there were no other identifiable opportunities for further assessment. We are aware from information from Ms A there was an assessment of autism undertaken in relation to Mrs X's son but we are not aware at this point of when this was undertaken and by whom or whether this assessment process included looking at the home environment.

The police treated the enquiry on 12 April 2013 as a concern for welfare as no specific incident of domestic violence had been reported. They were responding to a friend's concerns for Mrs X's welfare and they saw her, spoke to her and felt reassured of her wellbeing. However this decision was based solely on a brief conversation with Mrs X and officers did not attempt to gain access to the home despite the friend having reported concerns relating to Mr X's behaviour, including that he had been aggressive in the past. In hindsight and having spoken to Ms A, we are aware that, had the police

officers entered the family home, it is likely that this would have led to a more in-depth assessment. This incident was therefore a missed opportunity for assessment of domestic violence.

Relate did recognise the need for further assessment following their initial assessment that raised some concern about controlling behaviour from Mr X. However, it would appear that these concerns were not significant enough to take action other than placing them on the Relate waiting list.

The GP practice appropriately made a referral of Mr X into mental health services.

These offers of intervention however were not accessed as the assessment appointments were undertaken less than two weeks prior to the homicide.

Whilst outside the timescale of this review, Health Visitor Services had contact with the family when the children were infants. Records indicate that possibly, whenever she was seen, Mrs A was in the presence of Mr A as he ran his business from the home. This may have meant that professionals did not take the opportunity to ask routine questions regarding domestic violence or abuse.

- **Do assessments and decisions appear to have been reached in an informed and professional way?**

All assessments undertaken and decisions to offer services in response were reached following agency policies and procedures.

Northumbria Police followed force procedures in responding to a concern for welfare, including checking for any history of domestic violence and whether the children were known to Children's Services.

The Relate IMR author comments that, having reviewed the case, they are satisfied that the counsellor properly consulted with the Internal Practice Helpline in response to information from the assessment that raised concerns. In response, couple counselling was deemed inappropriate at that point.

The assessment of Mr X undertaken by Dr C was extremely comprehensive and there was a clear follow-up plan both in relation to his mental and physical health.

- **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?**

No agencies identified any significant level of risk in their interventions with Mr and Mrs X. Indeed, apart from Relate's assessment that there was some indication of controlling behaviour from Mr X towards Mrs X, domestic violence or abuse were not identified as issues within agencies' contacts.

The Police carried out standard checks in relation to domestic violence and ascertained Mrs X's welfare. As already highlighted in this report, had they entered the home as part of the response to the concern for Mrs X's welfare, this may have resulted in further information coming to light. However, as already commented, there may have been no disclosure beyond that shared with Relate six days later.

The clearly presenting issue for the GP practice was Mr X's mental health and Dr C undertook a thorough assessment and offered appropriate referral to Primary Care Mental Health Services as well as a follow-up appointment at the surgery in relation to associated physical health issues.

As already outlined, Relate offered individual structured interviews in response to their concerns about potential indicators of domestic violence. The identified aims of these interviews had it been taken up would have been to enable Mr X to consider his behaviour and for Mrs X to consider her safety and choices and the well-being of her children.

- **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?**

Mrs X had only two contacts with agencies where there was an opportunity to ascertain how she was feeling and what she wanted to happen.

In the incident on 12 April 2013, when the police attended at her home, she stated to officers that she was fine and was surprised that the police were there. Information provided by Ms A, who had called the police, suggests that Mrs X may have been caught between a desire to hide what was going on in her family life, feeling ashamed of the poor state of her home, and fear of reprisals from Mr X should she disclose to the police about his controlling behaviour and threats. Given the information shared with the police by Ms A in relation to Mr X's aggressive behaviour towards Mrs X, perhaps the police officers should have ensured that they had spoken to Mrs X alone. Without entering the home or arranging to see Mrs X alone at another time, they could not have made an accurate assessment of her wishes or whether she was under pressure from Mr X. It is impossible to say whether the police taking this course of action would have led to further disclosure by Mrs X.

Ms A stated that she felt that the police response to her when she contacted to share her concerns was appropriate and she was pleased that they were attending the home to check on her welfare. She confirmed that the police did get back in contact with her after they had spoken to Mrs X and that she had later spoken to Mrs X. She expressed that, in hindsight, she was really disappointed that the police had not taken the step of entering the family home to enquire further as she felt that this would have led to some kind of action being taken.

Mrs X completed a 'Client Before Service' form prior to the initial assessment session. On the 'Before Service' form, which was completed individually, Mrs X indicated concern about the possible emotional impact on the children of witnessing Mr X's self-harm. In the initial interview session she said she felt Mr X emotionally blackmailed her by threatening self-harm.

The assessment session was undertaken jointly with Mr X. It was considered inappropriate to discuss the options of possible signposting in this context. On the basis of the information Relate had been given, the subsequent individual sessions would

have been the appropriate opportunity for follow-up on such issues as signposting with Mrs X.

- **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?**

As commented above, Mrs X made some disclosure to Relate via the completion of the 'Client before Service' form. The response as outlined already was to appropriately offer individual sessions. This was following the counselor undertaking the assessment having consulted with the Relate Practice Helpline.

As already outlined in section 2.2 of this report, Mrs X had disclosed quite extensively to her friend, Ms A, about Mr X's controlling and aggressive behaviour towards her. Ms A shared some of this information with the police on 12 April 2013, expressing concern about her safety after she had been unable to contact her. The police responded by visiting Mrs X at her home that day. As already outlined she stated that she was fine and had no concerns about her own welfare. In the circumstances and, in the absence of any police intelligence in relation to domestic violence, the action taken by the police to record this as a concern for her welfare with no further action to be taken would appear to have been in line with force policy and procedures. However, one of the learning points from this case may be that agencies should be less reliant on standard checks and presentation of potential victims and give more weight to information shared by friends or family members. As noted earlier in this report, Northumbria Police have amended their procedures to ensure that third parties disclosing information in relation to domestic violence or abuse are revisited where there are inconsistencies between information provided and the presentation of the victim.

- **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?**

Information provided by Ms A indicated that there was a pattern developed over years of Mrs X being subject to coercive control by Mr X. Ms A described him undermining Mrs X's self-confidence and isolating her from support networks through making their home an uncomfortable place to be both in terms of the physical and social

environment. He would frequently undermine her in front of others and behaved in an erratic and unpredictable way. Mrs X had told Ms A that, prior to her relationship with Mr X, she had a successful career and having been a self-confident woman. Ms A also commented that Mrs X attempted to portray as much as possible to the outside world that she had a 'normal' life. This is typically indicative of a domestically abusive relationship where the perpetrator absolves himself of any responsibility for his abusive and controlling actions and the impact of this on the family and the victim feels responsible both for him and managing the impact of his actions on her and her children. In this case, this is evident in Mrs X taking the steps of referral and follow-up appointments to the GP and Relate.

Mrs X's presentation to the three agencies participating in this review needs to be understood in the above context.

It may be that her reluctance to disclose to the police was due to a mixture of fear of reprisals from Mr X and her not wishing them to see 'behind closed doors' and having to deal with the potential consequences. This reluctance to engage must also be seen as an impact of suffering from domestic abuse, where she took on responsibility for managing the consequences of Mr X's abusive behaviour.

The GP practice noted that Mrs X was present throughout the consultation on 18 April 2013 and presented as concerned about and supportive of her husband. This presentation was again likely to be indicative of a mixture of fear of Mr X and her feeling that she had to take responsibility for Mr X's problems.

Relate have commented that there was at least an indication of the victim being subject to coercive control. However, as this information was limited and there was only one assessment session, it was difficult for them to say whether this controlling behaviour would have impacted negatively on her ability to access services, or indeed whether it had any relevance to her not following up on the initial appointment. That Mrs X made the telephone call to book an initial appointment further suggests that she felt no restriction in accessing services. Ms A commented that she spoke to Mrs X after she had attended the appointment at Relate and that Mrs X had been in a very positive

mood, feeling positive about her future having taken steps to make some disclosure about Mr X's controlling behaviour towards her.

Similarly, there is no evidence from the GP records to indicate that Mrs X experienced any restriction in consulting the GP, both in relation to her own and her husband's health.

In the interview undertaken with Mr X, his focus was almost exclusively on what he viewed as the unreasonable behaviour of Mrs X and the influence of one of her friends. He described this as a "poisonous relationship" and that this friend was attempting to undermine their family life, which to his view had been unproblematic until two weeks prior to the murder. As already stated in the report, Mr X displayed no discernable signs of remorse or empathy in relation to Mrs X's death, rather focusing purely on the impact of his wife's and her friend's actions on him. He did not at any point refer to the murder but rather focused on how he felt he had been treated. This presentation served to reinforce the view put forward by Ms A that Mrs X had been subject to a pattern of coercive control for a number of years, if not throughout her relationship with Mr X.

- **Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the alleged perpetrator and their families? Was consideration for vulnerability and disability necessary?**

Mrs X, Mr X and their children are all of white European descent with English as their first language. There were no noted factors in relation to religious identity, disability or anything that would suggest any particular vulnerability. This is obviously based on the limited information that was held by agencies.

**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?**

Given the limited information held by the three agencies producing IMRs, there were no further questions arising in addition to those covered within the terms of reference for this report.

The police IMR did note that the area where the family lived is a safe area of the city of Newcastle-upon-Tyne. The area has a relatively low level of crime, particularly in relation to incidence of violent crime. There were no other reported violent crimes in the sector that day and the last domestic homicide detected occurred in 2008. Whilst recorded incidents of violent crime are low in what is the relatively affluent area of the city of Newcastle within which the family lived, there are indications from this case that perhaps domestic violence is a more 'hidden crime' in such areas. Certainly, this is the picture drawn by Ms A, who expressed the view that many people knew about Mr X's controlling behaviour but that they chose to withdraw support from Mrs X and the children because they did not wish to get involved. Ms A referred to her conversation with a local vicar in the aftermath of Mrs X's murder, that the vicar stated in referring to the prevalence of domestic violence, that people "wouldn't believe what goes on" in the area.

It is worth considering that the decision of the police officers to not proceed any further with enquiries may have been based on perceived stereotypes about an affluent, middle class area where involvement with justice and social work agencies was rare. It is also of note that the highest rate of referrals to Relate Tyneside and Northumberland is from the area where Mr and Mrs X lived. There is likely to be a proportion of referrals to Relate that involve domestic violence or abuse but are presented as relationship difficulties.

- **Are there ways of working effectively that could be passed on to other organisations or individuals?**

Again, given the very limited involvement of participating agencies, there has been no practice highlighted as being either good or poor, particularly in relation to domestic violence. All agencies followed relevant procedures in responding to the issues presented.

- **Were senior managers or other agencies and professionals involved at the appropriate points?**

The contacts that the police and GP practice had with Mrs X and Mr X prior to the date of the murder did not raise sufficient concern to necessitate reporting to a senior

manager. The Relate counsellor did contact the Relate Internal Practice Helpline, which is staffed by senior practice consultants, as a result of possible indicators of domestic violence. They also accessed clinical supervision following the initial assessment session. These actions were in line with Relate's policies and procedures.

- **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?**

Agencies participating in this review had very limited involvement with Mrs X and Mr X, and none with their children. In light of this and that there were no major concerns identified in relation to domestic violence prior to the murder, it is not possible to identify from this case whether the practice of participating agencies is effective in safeguarding victims or managing 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?**

This case has highlighted that domestic violence and abuse can be particularly 'hidden' in more affluent areas where there may be less wider family support and there is much less involvement of criminal justice and health and social care agencies. Indeed, this was reflected in the very limited involvement that agencies had with the family. A picture has emerged, albeit from limited information, where family life was seen as a private matter by those living in this affluent area of the city. This perception may also be reflected in agency interventions, in this case the police, in such areas, and thus may need to be addressed within agency training and practice.

The GP practice gave a significant amount of time to undertake a thorough assessment into Mr X's mental health and initiated an appropriate referral to Primary Care Mental Health Services.

Relate were the one agency to identify potential domestic abuse in their initial assessment and they followed correct procedures to offer individual work to both Mrs X and Mr X. They are undertaking a review of procedures in relation to making prompt

contact with a potential victim of domestic abuse where there may be a delay in awaiting an allocated appointment following the initial assessment.

Whilst there was no cross-agency work in this case and no risks evident to agencies who had contact with the family that would have merited this, the review process led to discussion about improving links between agencies, particularly between statutory and third sector organisations. As a result a previous DHR in the Newcastle area, a 'Safeguarding Adults Information-Sharing Flowchart' was developed. It was agreed that this will be shared with Relate.

- **How accessible were the services for the victim and perpetrator?**

It does not appear that either Mrs X or Mr X had any difficulty in accessing services. Mrs X made telephone contact with Relate on 15 April 2013 and was offered the initial appointment on 18 April 2013. GP services were very responsive to both Mrs X and Mr X with four separate contacts in three weeks leading up to the date of the murder. Mrs X made contact by telephone on two occasions, in relation to her own and her husband's health. She also attended the consultation on 19 April 2013 along with Mr X as well as an individual appointment in relation to her own health. A follow up appointment was arranged for Mr X on 29 April, the day of the murder.

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

There is no information that has emerged from agencies contact with either Mrs X or Mr X that would suggest that referral into MARAC should have been instigated in this case. There were no identified instances of physical violence prior to the murder and only limited disclosure of domestic abuse to the police and Relate. The incident when the police were involved was dealt with as a concern for welfare with no further action to be taken. There were no grounds for the police undertaking a DASH risk assessment in relation to this incident and no significant domestic violence risk factors have emerged from the IMRs undertaken by the Newcastle North and East Clinical Commissioning Group and Relate Northumberland and Tyneside.

#### **4 To What Extent Was Mrs X's Death Predictable or Preventable?**

It is clear from the IMRs 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 limited contacts that agencies had there were some indicators that Mr X had behaved in a controlling manner towards Mrs X. Ms A shared information with the police in relation to him having smashed things in the home and in the Relate assessment 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.

We now know via information from the criminal trial and from Ms A that there were significant risk factors present. Mr X was behaving in a controlling manner, 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.

Research into domestic homicides suggests that obsessive jealousy and overtly controlling behaviour are indicators of potential high risk of domestic violence (Dobash and Dobash et al 2002). However, the limited information available to agencies prior to the day of the murder was insufficient to indicate either that Mr X was obsessively jealous or behaving in an overtly controlling manner.

Research has also demonstrated a link between suicidal ideation on the part of perpetrators, often linked to obsessive jealousy and control (Hart 2001). Whilst Mr X was evidently suffering from depression and had self-harmed, suicidal ideation does not appear to have been a factor in this case. The GP concluded from a comprehensive assessment of Mr X on 19 April that he had no suicidal intent and there is no evidence that Mr X had taken any steps to harm himself in the aftermath of him murdering his wife.

Whilst the presentation of a potential victim of domestic violence is not necessarily a reliable indicator of risk, as outlined above there was an absence of high risk factors

that would have led agencies to question Mrs X's presentation to them as being unafraid and supportive of her husband.

We are now aware that there was a long history of Mr X using controlling and abusive behaviour. The police could have possibly gained more information had they entered the family home or arranged to speak to Mrs X alone but there is no guarantee that she would have shared any information beyond that which she shared with the Relate counsellor in the interview that took place six days later.

Given that so little information in relation to domestic violence and abuse was available to agencies, we would conclude that none of the agencies involved in this case could have predicted or taken steps to have prevented the tragic loss of Mrs X's life.

## **5 Conclusions and key learning points**

- **Domestic homicides that are very difficult to predict due to the 'hidden' nature of the domestic violence, 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. They noted that:

*“It came “out of the blue” is often said when a man with no known history of criminality kills his intimate partner. This reflects a belief that a “conventional man” without a criminogenic past or a problematic personal history would not commit murder.”*

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 in our interview with him. Additionally, 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, as outlined in the previous section of this report, no strong indicators of high risk from the information they did obtain – the police from Mrs X’s friend, Ms A, and Relate from Mrs X herself. This case again highlights the hidden nature of some cases of domestic violence, particularly in populations that are not traditionally ‘policed’ by social care and criminal justice agencies. Information from the criminal trial indicated that Mrs X had shared information with two friends about abusive, controlling behaviour that she was experiencing from Mr X. The interview with Ms A 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.

The children’s school did not identify any concerns in relation to domestic violence or abuse. In light of the review, the key findings and conclusions of the review will be shared with school leadership.

- **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. This was true in the case of Mrs X, whose family remained living in the South of England. Additionally, it would appear that 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. In the interview undertaken with him, much of his focus was on his perceived negative influence of the one friend who sought to support his wife. This served to reinforce this emerging picture of their family life.

Additionally, social care and criminal justice agencies are much less active in affluent areas. This can sometimes lead to professionals being less proactive in responding to expressed concerns.

## **6 Recommendations**

### **6.1 General Recommendations**

The following recommendation relates to both the points outlined above in the 'conclusions' section and is a recommendation that is across agencies. Detail of the implementation is given in the action plan at the end of the report.

- 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.**
  
- 3. Relevant findings and conclusions from the review to be shared with the children's school.**

## **6.2 Recommendations - Individual Agencies**

Within the Individual Management Reviews undertaken by participating agencies no recommendations were identified. As an outcome of the review the following recommendations were identified that relate to individual agencies. These relate to specific service issues and are also included in the action plan for the review.

### **Relate Northumberland and Tyneside**

To review policies and procedures in relation to responses to disclosure of domestic violence and abuse to ensure that Relate staff provide appropriate information, advice and support at the earliest possible opportunity.

## 7. Action Plan

Recommendation	Scope of Recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of Completion and Outcome
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.	Local	<ul style="list-style-type: none"> <li>• Discuss with partners and identify initial ideas</li> <li>• Discuss with Communications Teams</li> <li>• Scope approach and timescales</li> <li>• Identify finance</li> <li>• Seek sponsorship</li> <li>• Agree awareness raising campaign</li> <li>• Implement campaign</li> </ul>	Safe Newcastle	<ol style="list-style-type: none"> <li>1. Meeting held with partners proposal written up</li> <li>2. Meeting held with Communications Teams</li> <li>3. Confirm finance</li> <li>4. Develop project plan</li> <li>5. Run campaign</li> </ol>	<ol style="list-style-type: none"> <li>1. June 2015</li> <li>2. August 2015</li> <li>3. August 2015</li> <li>4. August</li> <li>5. September 2015</li> </ol>	
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.	Local	<ul style="list-style-type: none"> <li>• All agencies to identify their process for responding to concerns in relation to domestic violence and abuse by family and friends and where this is available/how this is made known to staff.</li> <li>• To provide feedback to Safe Newcastle as to the above including any gaps within the process and how these will be addressed.</li> </ul>	Safe Newcastle	<ol style="list-style-type: none"> <li>1. SNU to contact all partnership agencies to request information.</li> <li>2. Agencies to review processes.</li> <li>3. Agencies to return responses including any actions to be taken to SNU.</li> </ol>	<ol style="list-style-type: none"> <li>1. 14<sup>th</sup> November 2014</li> <li>2. 14<sup>th</sup> December 2014</li> <li>3. 19<sup>th</sup> December 2014</li> </ol>	

Relevant findings and conclusions from the review to be shared with the children's school.	Local	<ul style="list-style-type: none"> <li>• Chair to agree with Safe Newcastle information to be shared with the school.</li> <li>• Chair to contact headteacher of school to set up meeting.</li> <li>• Meeting to take place between Chair and headteacher.</li> </ul>	Chair of Review	<ol style="list-style-type: none"> <li>1. Meeting agreed with headteacher of school.</li> <li>2. Meeting completed and relevant information shared.</li> </ol>	<ol style="list-style-type: none"> <li>1. 14<sup>th</sup> November 2014.</li> <li>2. 12<sup>th</sup> December 2014. Completed</li> </ol>	
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### Individual Agency Actions

Relate to review policies and procedures in relation to responses to disclosure of domestic violence and abuse to ensure that Relate staff provide appropriate information, advice and support at the earliest possible opportunity.	Local - individual agency	<ul style="list-style-type: none"> <li>• Newcastle Safeguarding Adults team to meet with Relate to discuss multi-agency flowchart for responding to domestic abuse.</li> <li>• Relate to review how this may assist in revising procedures.</li> <li>• Relate to inform Safe Newcastle of any revised policies or procedures relating to the disclosure of abuse.</li> </ul>	Relate.	<ol style="list-style-type: none"> <li>1. Meeting agreed between Relate and Safeguarding Adults team.</li> <li>2. Meeting completed between Relate and Safeguarding Adults team.</li> <li>3. Review of policies and procedures relating to disclosure of domestic abuse and violence completed by Relate.</li> <li>4. SNU informed of any revised policies or procedures relating to the disclosure of abuse.</li> </ol>	<ol style="list-style-type: none"> <li>1. End October 2014</li> <li>2. End December 2014</li> <li>3. End January 2014</li> <li>4. End January 2014</li> </ol>	
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## **8 Bibliography**

Dobash, R.P., Dobash, R et al (2002): *Homicide in Britain*. Research Bulletin.  
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Home Office (2013) *Domestic Homicide Reviews: Common Themes Identified as Lessons to be Learned*