Warrington Community Safety Partnership

Domestic Homicide Review

Overview Report

Julie

Died November 2018

Chair Ged McManus
Author Mark Wilkie

Date finalised June 2020

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1 Introduction

1.1 This report of a Domestic Homicide Review examines agency responses and support given to Julie[1], a resident of Warrington prior to her death in November 2018. The DHR panel would like to offer their condolences to Julie's family on their tragic loss.

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

1.3 Julie and Brian[2] were married and lived together on the outskirts of Warrington. They had a daughter together, Lauren[3] who lived with them and is now in full time education.

1.4 Julie had not worked since 2011 when she lost her job. She suffered from poor mental health and had been diagnosed with Anxiety, Depression and Autistic Spectrum Disorder. She sometimes self-harmed but did not have suicidal ideation. She found difficulty with social inclusion but was very interested in horses. The couple maintained a stable with four horses and family activities surrounded their own horses as well as attending at and competing in equestrian events.

1.5 On 2 November 2018, the Police were called to the stables owned by the family. On arrival the police found Julie's body. She had serious head injuries. Brian, who had called the police was arrested at the scene on suspicion of Julie's murder. A post mortem was carried out on Julie and gave severe head injury as the cause of death. Brian was bailed to enable further enquiries to be made. In April 2019, Brian was charged with Julie's murder.

1.6 At his trial evidence was given that Brian had attacked Julie with a crowbar. After he had killed her, Brian disposed of the murder weapon and returned home to change and dispose of his clothing, before returning to the stable. He then rang the emergency services and pretended that he had just found Julie who he said must have been attacked by a third party.

[1] A pseudonym chosen by the victim's family
[2] A pseudonym for the perpetrator chosen by the DHR panel
[3] A pseudonym for the victim's daughter chosen by the DHR panel

1.7 At Liverpool Crown Court Brian was found guilty of Julie's murder. He was sentenced to life imprisonment with a minimum term of 20 years.

Passing sentence, the Judge told Brian he was "an accomplished liar" who had woven "a web of deceit and lies".
He said Julie "had defensive injuries to both her hands. She must have been pleading and begging for you to stop".
"You had had enough of her, saw the opportunity that presented itself that night to kill her and did so."

1.8 The review will consider agencies contact and involvement with Julie, the perpetrator and Lauren from 1 November 2014, until Julie's death in November 2018. This time period was chosen because the panel were aware that there had been a first contact with Adult Social Care during 2014. Background information prior to the terms of reference period was also available to the panel and is used in the report for context.

1.9 The intention of the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.10 **Note:**
It is not the purpose of this DHR to enquire into how Julie died. That is a matter that has already been examined during Brian's trial.

2 Timescales

2.1 This review began on 17 October 2019. This followed the perpetrator's trial that concluded 15 October 2019. The Panel met on four occasions prior to its work being interrupted by restrictions in place as a result of the corona virus. Work then continued by telephone conferencing and exchanges of documents. The DHR was concluded on 4 June 2020, following consultation with Lauren and her Victim Support Homicide worker which was conducted using Microsoft Teams video conferencing.

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including their support worker, during the review process.

3.2 The report uses pseudonyms in order to protect the identity of the victim, perpetrator and their child.

4 Terms of Reference

4.1 The purpose of a DHR 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 inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

[Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7]

4.2 Timeframe under Review

The DHR covers the period 1 November 2014 to the homicide in November 2018.

4.3 Case Specific Terms

Subjects of the DHR

Victim: Julie 49 years

Perpetrator: Brian 50 years

Daughter of Julie and Brian: Lauren 17 years

Specific Terms

1. What indicators of domestic abuse did your agency have that could have identified Julie as a victim of domestic abuse by Brian and what was the response?

2. What knowledge did your agency have that indicated Brian might be a perpetrator of domestic abuse against Julie and what was the response?

3. What knowledge did your agency have that indicated Brian might be a victim of domestic abuse by Julie and what was the response?

4. What thought was given by your agency as to whether Brian or Julie was the primary perpetrator?

5. What services or signposting [including substance misuse services] did your agency provide for, or offer to, Julie or Brian, and were they accessible, appropriate and sympathetic to their needs and were there any barriers in your agency that might have stopped Julie or Brian from seeking help for the domestic abuse?

6. Within the services that you provided to Julie and Brian what consideration did you give to Lauren's needs and did you consider or make any referrals to other services for Lauren?

7. Did professionals recognise the potential psychological impact on Lauren through the effect of Julie's health issues or the possibility of her witnessing domestic abuse?

8. What services did your service provide to Lauren?

9. What knowledge or concerns did Julie and Brian's families, friends or employers have about their domestic abuse and did they know what to do with it?

10. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Julie and/or Brian?

11. Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Julie and/or Brian, or on your agency's ability to work effectively with other agencies?

12. What learning has emerged for your agency?

13. Are there any examples of outstanding or innovative practice arising from this case?

14. Does the learning in this review appear in other domestic homicide reviews commissioned by Warrington Community Safety Partnership?

5 Methodology

5.1 Julie was killed in November 2018 and Brian was arrested for her murder, however he was released on bail. At this point it was not certain that this was a domestic crime however, Cheshire Police made Warrington Community Safety Partnership aware of the situation. In April 2019 Brian was charged with Julie's murder and Warrington CSP were informed. This now fitted the criteria for a DHR to be commenced. Warrington Borough Council appointed Ged McManus as the independent chair in July 2019. Thereafter a DHR panel was assembled from agencies judged to have had an involvement with the family or contribution to make to the review. Care was taken to ensure people with additional independence and domestic abuse expertise were invited to be panel members. The actual process did not start until the conclusion of Brian's trial in October 2019 as members of the family were witnesses at the trial.

6 Involvement of Family, friends, work colleagues and wider community

6.1 The DHR Chair wrote to Julie's mother and daughter inviting them to contribute to the review. The letters included the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet. Julie's daughter Lauren agreed to contribute to the review and was seen by the Chair and Author. Given her age she was supported by a Victim Support Homicide worker and members of the family that she was living with. Julie's mother declined the offer. No other friends or members of the family were identified that could assist the review.

6.2 **The perpetrator**

6.2.1 Brian agreed to take part in the review and was seen by the Chair and Author in February 2020 in prison. Information that he gave in relation to the background to the case and the family situation is used in the report.

7 **Contributors to the review/ Agencies submitting IMRs[4]**

7.1

Agency	**Contribution**
Cheshire Constabulary	IMR
North West Ambulance Service (NWAS)	IMR
Bridgewater Community Healthcare NHS Foundation Trust	IMR
Warrington Clinical Commissioning Group	IMR
Warrington Borough Council Education	IMR
St Helens CCG	IMR
Clatterbridge Cancer Centre NHS Foundation Trust (CCC)	IMR
North West Boroughs Healthcare NHS Foundation Trust	IMR
Warrington Borough Adult Social Care	IMR
Warrington and Halton Teaching Hospitals NHS Foundation Trust	IMR
Cheshire Fire Service	IMR
Children's Social Care Warrington Borough Council	Short Report

[4] Independent Management Reviews [IMRs] are detailed written reports from agencies on their involvement with the subjects of the review.

7.2 As well as the IMRs, each agency provided a chronology of interaction with subjects of the review including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of the subjects or any involvement in the provision of services to them. The IMR was quality assured by another senior member of staff and the DHR panel accepted that this was a reasonable and proportionate approach.

7.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the subjects over the period of time set out in the 'Terms of Reference' for the review. It should summarise the events that occurred, intelligence and information known to the agency, the decisions reached, the services offered and provided to subjects and any other action taken.

7.4 It should also provide an analysis of events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why.

7.5 Each homicide may have specific issues that require exploration and each IMR should consider carefully the individual case and how best to structure the review in light of the particular circumstances.

8 T**he review panel members**

Ged McManus	Independent Chair
Mark Wilkie	Support to chair and author
Sue Wallace	Detective Constable Cheshire Constabulary
Margaret Macklin	Head of Adult Safeguarding and Quality Assurance Warrington Borough Council
Theresa Whitfield	Head of Service, Community Safety & Resilience Warrington Borough Council

Julie Ryder	Designated Nurse Safeguarding Adults Warrington Clinical Commissioning Group (CCG)
Andy Jones	Service Manager Children's Social Care Warrington Borough Council
Ellen Parry	Assistant Head of Service Warrington Borough Council Education
Wendy Teague Administrator	Warrington Borough Council
Jacqueline Hodgkinson	Adult Safeguarding Lead North West Boroughs Healthcare NHS Foundation Trust
Jackie Rooney	Head of Safeguarding Clatterbridge Cancer Centre NHS Foundation Trust (CCC)
Deborah De Jong	Clinical Specialist for Additional Needs Clatterbridge Cancer Care Centre NHS Foundation Trust
Louise Pendleton	Specialist Nurse Safeguarding Adults Bridgewater Community Healthcare NHS Foundation Trust
Wendy Turner	Lead Named Nurse Warrington and Halton Teaching Hospitals NHS Foundation Trust
Dr Lisa Lang	Named Safeguarding Adults Consultant Warrington and Halton Teaching Hospitals NHS Foundation Trust
Sally Starkey	Chief Officer Warrington's Women's aid
Steve Cullen	Chief Officer Warrington District Citizens Advice

9 Author and Chair of the overview report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 set out the requirements for review chairs and authors. In this case the chair and author were separate people.

9.2 Ged McManus was chosen as the DHR Independent Chair. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He is currently Independent Chair of a Safeguarding Adult Board in the north of England (not Cheshire) and was judged to have the skills and experience for the role. Mark Wilkie supported the independent chair and wrote the report. He has written previous DHRs. Both practitioners served for over thirty years in different police services in England. Neither of them has previously worked for any agency involved in this review. Ged McManus and Mark Wilkie have contributed to a previous DHR in Warrington.

10 Parallel Reviews

10.1 An inquest was opened and adjourned immediately following Julie's death. The inquest was closed without resuming after the result of the trial.

10.2 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process.

11 Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

age
disability
gender reassignment
marriage and civil partnership
pregnancy and maternity
race
religion or belief
sex
sexual orientation

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:
  (a) P has a physical or mental impairment, and
  (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 In December 2016 Julie was diagnosed with ASD. The condition impacted on her ability to communicate and socialise with others. This may have been a disability within the meaning of the Equality Act.

11.3 The panel heard that a DWP investigation found that Julie could carry out many day to day activities as a result of which her benefit claims were adjusted.

11.4 All subjects of the review are white British. At the time of the review they were living in an area which is predominantly of the same demographic and culture. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

11.5 Domestic homicide and domestic abuse in particular, is predominantly a gender crime with women by far making up the majority of victims, and by far the vast majority of perpetrators are male. A detailed breakdown of homicides reveals substantial gendered differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018, according to the Office of National Statistics homicide report;

"There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner

Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims).

Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women).

12 **DISSEMINATION**

Julie's family
Home Office
Warrington CSP
Cheshire Constabulary
Warrington Adult Social Care
Warrington Children's Social Care
Warrington CCG
NWBH NHS Foundation Trust
Warrington and Halton Teaching Hospitals NHS Foundation Trust
Clatterbridge Cancer Centre NHS Foundation Trust (CCC)
Bridgewater Community Healthcare NHS Foundation Trust

13 BACKGROUND, OVERVIEW AND CHRONOLOGY

13.1 INTRODUCTION

13.1.1 This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the family and punctuated by subheadings to aid understanding. The information is from documents provided by agencies and the family and material gathered by the police during the homicide investigation.

13.2 Julie

13.2.1 The majority of the information about Julie was supplied by Brian. Some of this information is corroborated from other sources including, IMRs, Court reporting and Lauren.

13.2.2 Not much is known about Julie's younger years however, it is known that in her late teens and early twenties that she lived in the Atherton area of Greater Manchester and worked for an insurance company in Manchester.

13.2.3 Julie had her own house in this area which she had bought with a previous boyfriend. When this relationship ended she kept the house.

13.2.4 Julie met Brian on her 21st birthday and they started a relationship. She sold her house soon after and they moved in together in rented accommodation.

13.2.5 Julie was described as very quiet and wasn't keen on large gatherings or noisy situations. She did however like horses and regularly rode including in competitions. She bought her own horse called Marcus which was stabled nearby.

13.2.6 Throughout all Julie's adult life, she suffered from mental health problems. These included: Anxiety, Depression, self-harm, Autism Spectrum Disorder (ASD) with associated Anxiety and Agoraphobic symptoms. Her illnesses made social interaction difficult and stressful. She was treated by her local Mental Health Service providers over a period of years.

13.2.7 Julie worked for the Department of Work and Pensions (DWP). She was primarily based in a department that was administrative where she used her

skill with statistics. Unfortunately, she was moved to a public facing department which just did not work out because of her underlying mental health issues. Julie found the noisy environment and uncertainty of the daily routine too difficult to cope with. The consequence of this change of role resulted in her being off sick for long periods of time, culminating in her being dismissed in 2011. In 2015 she went to a Tribunal to appeal the dismissal. She was awarded a sum of money. This dismissal and process appears to have precipitated a worsening of her mental health.

13.2.8 Julie had difficulty communicating with others at work and in other social settings*. Autism.org.uk states.*

'In particular, understanding and relating to other people, and taking part in everyday family, school, work and social life, can be harder. Other people appear to know, intuitively, how to communicate and interact with each other, yet can also struggle to build rapport with people with ASD. People with ASD may wonder why they are 'different' and feel their social differences mean people don't understand them.

Autistic people, often do not 'look' disabled. Some parents of autistic children say that other people simply think their child is naughty, while adults find that they are misunderstood.'

13.2.9 In December 2016 Julie was diagnosed with ASD

13.2.10 Julie's passion was to spend a lot of her time when she was well at her stables riding horses as she found other social interactions very difficult and challenging.

13.2.11 In 2017, Julie was diagnosed with bladder cancer and she was undergoing treatment for the condition when she was killed.

13.3 **Brian**

13.3.1 Brian was born in Salford and studied computing at Technical College between 1985-87.

13.3.2 He had a career which used his IT skills including a period of time at the DWP. His last job was as a Solution Architect for Barclays Bank in the position of an Associate Vice President.

13.3.3 It appears that Brian had been a stabilizing factor in the family when Julie was struggling with her mental health. He was regularly called by Lauren's schools or health professionals that needed help with Julie. Their Daughter Lauren described him as, "The rock and would try and fix things".

13.3.4 Brian supported Julie and Lauren financially throughout and especially in the years when Julie was not working. They had their own house, vehicles and horses.

13.4 Julie and Brian

13.4.1 Julie met Brian on her 21st birthday. Initially they lived in rented accommodation and then bought a house which took some time to renovate. They married in 1997 and Julie went to work for the DWP. Brian joined the DWP around the same time. In 2001 they had their only child together, Lauren.

13.4.2 Julie found living on an estate where there were children playing on the street near her house difficult to cope with and this caused a lot of unrest with the neighbours. As hard as she tried she could not cope so they decided to move to a new house to help Julie.

13.4.3 The family moved to a house near Warrington and also bought land with stables on it where they kept their 4 horses. Julie and Lauren rode their horses which were kept at their stables with Lauren competing in dressage competitions.

13.4.4 The family never went on holiday but they would all attend dressage competitions where they would be involved in the judging or Lauren would be competing.

13.4.5 Lauren reported that her relationship with her mum was a strained one with Julie always being very critical about her and her actions and also changing from lovely to nasty at the flick of a switch

13.4.6 Lauren was described by her Secondary school as being an excellent pupil who achieved a set of high grades in her GCSEs. However, they also mentioned that in interactions with the school Brian was always the more reasonable, calmer parent when dealing with Lauren's issues in school. Julie was often volatile, with an aggressive tone and the instigator of causes of conflict. Lauren was a model student and her behaviour did not cause need for parental

meetings. All interactions / conflict with school was instigated by Julie, usually unhappy at Lauren's perceived lack of excelling. For example, after collecting a number of awards at celebration evening, Julie chose to challenge Lauren and staff for the one award she did not receive.

13.4.7 Throughout their married life Julie suffered with both her mental and physical health. Because of her mental health issues practitioners found that dealing with her physical health could be problematic. During most of these interactions Brian or Julie's mother would attend appointments with her and generally act in what was perceived as a supportive manner. The panel did not think that it was necessary to include all the details about Julie's physical conditions as they were not relevant to the review.

13.4.8 The following table contains important events from within the review timeframe which help with the context of the Domestic Homicide Review. It is drawn up from material provided by the agencies that contributed to the review. Analysis of these events appears at section 14 of the report.

13.4.9 It should be noted that during the period under review Julie attended numerous appointments with her GP (physical and mental health) and practitioners from North West Borough Healthcare NHS Foundation Trust (primarily for help with her mental health). Only those appointments that are relevant are detailed.

13.4.10 Julie attended several appointments with the Clatterbridge Cancer Care to discuss her cancer treatment. As this contains invasive medical information only those relevant to this report are included.

Significant events	
Date	Event
2.12.14	Julie reported to police that she had been threatened by a male driver who had been speeding past their stables. She had asked him to slow down. Police attended and due to the actions of both Julie and the male advice was given regarding their behaviour.
26.1.15	Julie attended an appointment with a MH Consultant, Julie was accompanied by her husband. She was discharged back to her GP to enable access to Mental Health Matters.[5] In the past Julie had declined any support from a psychologist, however, Julie felt she was

[5] Part of the national Improving Access to Psychological Therapies (IAPT) programme.

	now ready to access psychological services from the Recovery Team.
15.5.15	Julie accompanied by Brian visited her GP who noted that she had a chronic history of psychiatry/psychology intervention Julie stated her sleeping was worse and was affected with her issues: disorganisation at home, forgetfulness, anxiety symptoms, low mood, lack of energy and had suicidal (though no planning) thoughts. A letter was written to her previous Psychiatric Consultant suggesting Julie be dealt with by secondary care.
1.6.15	Julie, accompanied by Brian visited her GP with similar problems as the last visit. The Doctor prescribed an increased dose of Olanzapine[6]
30.6.15	Julie had an appointment with her GP but Brian attended without Julie. He stated that Julie was becoming increasingly withdrawn and would not answer the phone. She was not doing anything at home with Brian doing all the domestic jobs. She had sent Brian to meet the Doctor as she would not represent herself. A re-referral to see a psychiatrist was suggested.
26.8.15	Julie attended with Brian an appointment with a consultant at NWBH. Both reported difficulties as reported previously. It was agreed to review Julie's medication. Details of a Carer skills programme were given to Brian. This programme would enable him to understand more about Julie's complex needs and is usually offered to families who have a person with Emotionally Unstable Personality Disorder (EUPD). Brian did not engage with this programme.
10.2.16	Julie attended her initial appointment with the Consultant at NWBH with her husband Brian. Brian described difficulties with her interactions with others and spoke about sticking to a script or the rules in social situations and struggling when others go off script. Julie made no eye contact during the appointment and often needed interrupting to engage in conversation. It was agreed that Julie would return next week to further consider goals for therapy. The first goal identified was to explore how Julie could attempt to manage her anxiety when situations didn't go as she had planned.

[6] Olanzapine is an atypical antipsychotic primarily used to treat schizophrenia and bipolar disorder.

17.2.16-11.11.16	Julie had a program of weekly sessions with a psychologist at NWBH to address her mental health issues. She attended the majority of these sessions but there were occasions when she either wasn't well or something disturbed her routine so she didn't attend. An example of this would be when there was a bank holiday during the week of her appointment.
May 2016	Julie's mother requested Adult Social Care complete a statutory assessment of Julie's needs in line with the Fair Access to Care criteria (which preceded the Care Act). Julie was receiving support from mental health services and was assessed not to be eligible for further services therefore the contact was closed.
9 December 2016	Julie was told that she fitted the criteria for an autism spectrum condition [diagnosis of ASD]
November 2016-March 2017	Julie was referred to the Mental Health Outreach Team by a NWBH psychologist who had been working with her. The team worked with Julie with social inclusion support as she was having difficulty leaving the home and meeting new people. The intervention centred on reducing her anxiety, accessing other local support groups and support to liaise with the Department for Work and Pensions around her disability benefits. This included some involvement from a local "Budget boosting club" to help her with her finances.
23.1.17	Julie visited her GP with Brian. She was upset about receiving a letter about her benefits. Julie was crying and said that she couldn't sleep and had set fire to the kitchen by accident (The Fire Service did attend but no other details were recorded). The GP increased her medication (Not stated what this was).
16.3.17	Julie and Brian attended an appointment at NWBH. They discussed with a nurse how autism impacts on Julie's life.
20.3.17	Julie asked her GP for a letter to support her in her ESA (Employment and Support Allowance) assessment by saying that she was not fit to attend the assessment center. This was provided.
24.8.17	Julie attended the endoscopy unit at Halton Hospital as a day patient. This was important as this was a diagnostic procedure for Cancer of

	the bladder. Julie attended with Brian, however he explained he had a family emergency and left. Julie became anxious about the procedure and left the department without having the procedure.
16.10.17	Julie attended Halton Hospital for the flexible cystoscopy but left prior to the procedure. The consultant wrote to her GP informing him of this and asked the GP for assistance in supporting the hospital team in treating Julie if this was indeed what she wanted. A new date was offered.
15.12.17	Julie attended Halton Hospital, on this occasion Brian stayed with her and the procedure was completed. Bladder cancer was suspected and Julie was listed for the removal of the tumour.
5.1.18	Julie, was admitted to Halton Hospital to have her tumour removed. Julie was admitted to a side room at her request in order to support her autism. However, staff found her eating. Following conversations with the Consultant the operation was cancelled. She became distressed, and attempted to cut her arms with a plastic cup that she had broken. A nurse phoned Brian and asked if he could come to the hospital to take Julie home. When she found out she said that she would beat him up if he came near her. Julie then ran from the ward. The hospital's Adult and Children's safeguarding teams were contacted for advice. Julie was discharged with arrangements for a follow up from the Recovery Team.
5.2.18	Julie again attended at Halton Hospital for her surgery however, once again there were problems with Julie's understanding of what was happening and she discharged herself without the treatment. Julie's consultant called her GP to discuss the problems they were having and it was decided that the GP would refer Julie to Whiston Hospital for her surgery.
25.2.18	Julie attended Whiston hospital for the surgery that had not been able to be carried out at Halton. This time the operation was completed.
16.5.18	Julie had a consultation at Clatterbridge Cancer Care to discuss her treatment.

21.5.18	Whilst at an outpatient appointment at Clatterbridge Cancer Care Julie became distressed and talked about suicide stating she had enough tablets to do it. The medication that Julie had on her was taken from her.
23.5.18	Clatterbridge Cancer Care sent a letter to the Head Teacher of Lauren's school requesting that the school provide additional help and support for Lauren at that time due to her mother's recent cancer diagnosis and pending radiotherapy treatment.
8.6.18	Julie attended Clatterbridge Cancer Care with Brian and Lauren to go through the treatment plan. Brian and Lauren were given written information on local support services for carers and teenagers whose parents have mental health issues.
28.10.18	Julie attended Whiston Hospital AED with suspected Pyelonephritis[7]. She was admitted to a ward and discharged on 31.10.18.
2.11.18	Cheshire Constabulary attended at the family stable where Julie was found dead. Brian was arrested at the scene on suspicion of her murder.
April 2019	Brian was charged with the murder of Julie and remanded into custody
15.10.19	At Liverpool Crown Court Brian was found guilty of Julie's murder. He was sentenced to life imprisonment with a minimum term of 20 years.

[7] Pyelonephritis is a kidney infection

14 ANALYSIS

14.1 What indicators of domestic abuse did your agency have that could have identified Julie as a victim of domestic abuse by Brian and what was the response?

14.1.1 No agency has reported that they had overt indicators that Julie was a victim of domestic abuse. Brian accompanied Julie to many medical appointments and indeed on some occasions attended GP appointments and made representations on Julie's behalf without her being present. All of these attendances were seen as being supportive in the context of Julie's medical conditions and her observed anxiety in attending some appointments. The panel found no evidence that medical professionals had asked Julie about the possibility of domestic abuse. The panel discussed this and thought that as there had never been any indicators of domestic abuse then medical professionals had acted reasonably.

14.1.2 The Crown Prosecution Service policy guidance on coercive control states[8];

Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities

[8] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or University
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next.

14.1.3 The panel considered the indicators of coercion and control in the context of the information available to it. Julie did not work after 2011 and following a DWP investigation her benefits were reduced. The panel assumed therefore that she was dependent on Brian for finance. However, Julie was able to manage a stable with several horses and the family had two cars and horsebox. Julie often spent weekends with her daughter attending at equestrian events.

14.1.4 The panel noted that Brian was often present at Julie's medical appointments and discussed whether this amounted to coercion and control. The evidence is that Julie often wanted Brian to be present in order to assist with

communication. On some occasions her mother also attended medical appointments in order to assist her. During all of the appointments no medical professional was ever given any for reason concern in relation to the couple's relationship. Brian's presence was always seen as supportive in relation to Julie's medical conditions.

14.1.5 The panel found no evidence that Julie had been subject to coercive and controlling behaviour from Brian.

14.2 **What knowledge did your agency have that indicated Brian might be a perpetrator of domestic abuse against Julie and what was the response?**

14.2.1 No agency has reported any overt knowledge that Brian might be a perpetrator of domestic abuse. Brian was seen as a supportive factor throughout all of Julie's medical appointments. There is nothing in Julie's medical history to indicate unexplained injuries or any incidents which could point, even in hindsight to domestic abuse.

14.2.2 The family did not come to the attention of the police for anything other than routine incidents that were not connected to domestic abuse.

14.2.3 Both the school that Lauren attended up to GCSE level and her sixth form college gave the panel information about incidents in which Julie was perceived to have acted unreasonably, for example refusing to wait if Lauren was a few minutes late leaving school and leaving Lauren behind to make her own way home. On these occasions Brian was contacted and was seen as someone who would resolve the problem in a reasonable and calm manner.

14.3 **What knowledge did your agency have that indicated Brian might be a victim of domestic abuse by Julie and what was the response?**

14.3.1 Brian on many occasions helped medical professionals to deal with Julie's sometimes challenging behaviour caused by her anxieties. Whilst Julie's behaviour was challenging, medical professionals did not see this as extending to domestic abuse.

14.3.2 On one occasion, during an admission to Halton hospital on 5 January 2018, Julie became very distressed and staff arranged for Brian to attend in order to support her. Julie said that if he attended she "would beat him up and go wild again". Although ward staff consulted the hospital safeguarding team on the day this information was not mentioned, however staff did record it. Consequently, the suggestion that Julie would 'beat up' Brian was never

challenged or followed up. The panel saw that this was a single comment made by Julie during a prolonged and challenging situation for staff to deal with and understood how such a comment could be missed whilst focussing on Julie's immediate physical and mental health needs. The comment was recorded retrospectively and honestly by staff who must therefore have thought it was important.

14.3.3 Lisa Croen director of the Autism Research Programme at Kaiser Permanente in Oakland, California states,

"Going to the doctor can be stressful for people with autism".

She plans to comb the records for clues that adults with autism use the healthcare system differently than do other adults.

"People with autism may be wary of preventative exams such as colonoscopies, for example, and may not find it easy to graduate from paediatricians to doctors who treat adults".[9]

14.3.4 Myles and Southwick in 1999 (1) described a Rage Cycle for adults and children with autism spectrum disorder (ASD) which includes high functioning autism (HFA). They describe what happens when the person with ASD fails to recognise or is unable or unwilling to prevent their build-up of anger. This Cycle of Rage has three parts: rumbling, rage and recovery.
Adults (men and women) and children with Autism Spectrum Disorder often have difficulty with anger; difficulty in recognising that they feel angry and an inability to manage or deal with these feelings. Outbursts of anger, even in adults, can seem to materialise for no reason[10]

Further comment is made on the Autism Help website,

Adults on the autism spectrum may be prone to anger, which can be made worse by difficulty in communicating feelings of disturbance, anxiety or distress.
Anger may be a common reaction experienced when coming to terms with problems in employment, relationships, friendships and other areas in life affected by autism or Asperger's syndrome. There can be an 'on-off' quality to

[9] WWW.spectrumnews.org
[10] https://www.theneurotypical.com/rage-cycle-in-hfa.html

this anger, where the individual may be calm minutes later after an angry outburst, while those around are stunned and may feel hurt or shocked for hours, if not days, afterwards. Family members and partners often struggle to understand these angry outbursts, with resentment and bitterness often building up over time. Once they understand that their loved one has trouble controlling their anger or understanding its effects on others, they can often begin to respond in ways that will help to manage these outbursts.

In some cases, the individual on the autism spectrum may not acknowledge they have trouble with their anger, and will blame others for provoking them. Again, this can create enormous conflict within a family or relationship. It may take carefully phrased feedback and plenty of time for the person to gradually realize they have a problem with how they express their anger.

14.3.5 No other agency has reported any indicator that Brian might be a victim of domestic abuse by Julie.

14.4 **What thought was given by your agency as to whether Brian or Julie was the primary perpetrator?**

14.4.1 Agencies did not recognise domestic abuse in this case. There were no reports to the police of domestic abuse and neither Julie or Brian is known to have sought support from any domestic abuse agency. There was therefore no opportunity for any agency to make an assessment as to whether Brian or Julie was the primary perpetrator?

14.5 **What services or signposting [including substance misuse services] did your agency provide for, or offer to, Julie or Brian, and were they accessible, appropriate and sympathetic to their needs and were there any barriers in your agency that might have stopped Julie or Brian from seeking help for the domestic abuse?**

14.5.1 Julie was appropriately referred between and treated by the health agencies involved in the review. There was no indication at any time that a referral for Julie or Brian to substance misuse services was appropriate or necessary.

14.5.2 It was clear to medical professionals that Julie relied heavily on Brian for support. It seems clear that mental health and physical issues suffered by Julie would have taken a toll on the couple's relationship. The panel discussed whether there may have been a perception that Brian could cope based on his presentation as a relatively affluent and articulate professional

man. There is evidence that Brian was offered support by health professionals in dealing with issues arising from Julie's illnesses on two occasions.

- In 2015, details of a Carer skills programme were given to Brian by NWBH. This programme would enable him to understand more about Julie's complex needs and is usually offered to families who have a person with Emotionally Unstable Personality Disorder (EUPD). Brian did not engage with this programme

- Staff at CCC gave him and Lauren written information on local support services for carers and teenagers whose parents have mental health issues.

A third offer of support was made by Lauren's sixth form college in 2018 and is detailed at paragraph 14.7.4 et al

14.5.3 The panel discussed whether Brian and Lauren could have been offered more support in managing their family situation and in doing so they referred to the National Institute for Clinical Excellence guidance which states.

Offer families, partners and carers of adults with autism an assessment of their own needs including:

- personal, social and emotional support
- support in their caring role, including respite care and emergency plans
- advice on and support in obtaining practical support
- planning of future care for the person with autism.

1.7.2 When the needs of families, partners and carers have been identified, provide information about, and facilitate contact with, a range of support groups including those specifically designed to address the needs of families, partners and carers of people with autism.

1.7.3 Offer information, advice, training and support to families, partners and carers if they:

- need help with the personal, social or emotional care of the family member, partner or friend, **or**
- are involved in supporting the delivery of an intervention for their family member, partner or friend (in collaboration with professionals).

14.5.4 The panel concluded that Clatterbridge Cancer Centre had complied with NICE guidance and indeed had gone beyond that by contacting Lauren's school to ensure that appropriate support was in place for her.

14.5.5 The previous occasion that Brian was offered support by NWBH in 2015 was prior to Julie's ASD diagnosis in 2016. The panel heard that the support offered to families of those with EUPD and ASD is very similar.

14.5.6 The chair and author of the report specifically asked Brian about support the family had been offered. He could remember being offered support and was grateful for the offer but had declined it. He said that they were a private family who preferred to deal with their issues privately and he did not feel that they would have taken up support however it was offered.

14.6 **Within the services that you provided to Julie and Brian what consideration did you give to Lauren's needs and did you consider or make any referrals to other services for Lauren?**

14.6.1 The services provided to Julie and Brian focussed on Julie's physical and mental health needs. Other than for routine medical issues Brian did not consult his GP.

14.6.2 Following Julie's cancer diagnosis, she discussed her concerns around supporting Lauren with staff at Clatterbridge Cancer Centre. This resulted in a letter to Lauren's school informing them of Julie's diagnosis and suggesting they provide additional psychological support to Lauren whilst her mother was undergoing radiotherapy treatment for bladder cancer at Clatterbridge Cancer Centre. The Clinical Specialist for Additional Needs at Clatterbridge Cancer Centre also spoke to Lauren's Teacher to seek confirmation that the school were aware of the issues in relation to Julie's diagnosis of cancer and Asperger's. Written information was provided to Brian and Lauren on local support services for carers, and for teenagers whose parents have mental health issues.

14.6.3 There is no evidence that Lauren's needs were considered by other agencies providing services to Julie. The single exception to this was on 5 January 2018, when Julie became very distressed during an admission to Halton hospital. [Cross reference to paragraph 14.3.2]. As a result of Julie's self-harming behaviour on that occasion ward staff made a referral to the hospital safeguarding children team. The safeguarding children team made an assessment on the information available

- That Lauren had not witnessed Julie's self-harming behaviour.
- Brian was a protective factor for Lauren and Julie.

As a result of the assessment that Lauren was not at immediate risk no further action was taken by the trust safeguarding team.

14.6.4 The panel discussed whether a referral to Children's Social Care could have been appropriate on this occasion. The panel member representing Children's Social Care told the panel that had a referral been received in such circumstances it would have been likely that an assessment would have taken place considering the supportive factors in Lauren's life, for example, school, Brian and her grandmother. It is possible that signposting or referral to other organisations for example Young Carers would have taken place.

14.7 **Did professionals recognise the potential psychological impact on Lauren through the effect of Julie's health issues or the possibility of her witnessing domestic abuse?**

14.7.1 As outlined at paragraph 14.6.2 Clatterbridge Cancer Centre recognised that Julie's health issues might have an impact on Lauren. As a result, there were professional contacts with Lauren's school by letter and telephone.

14.7.2 Lauren was judged to be happy and productive in school. She required support in dealing with Julie's high expectations of her and clashes they had at home, which she talked to staff at school about. A support network was put in place to help Lauren and she achieved excellent GCSE results.

14.7.3 Staff at Lauren's sixth form college were aware of the potential impact of Julie's health conditions on Lauren. Although Lauren had only been at the college for a short time when her mother was murdered, staff had responded to one incident where Julie was thought to have had an extreme response to Lauren losing a key.

14.7.4 The college told the review that following Julie's murder additional pastoral support and counselling was arranged for Lauren. However, when consulted about the report Lauren stated that the counsellor was involved with a third party and could therefore not see her. She thought that this would have been helpful but no alternative was suggested. She was also advised that as with every student she could access her personal tutor at any time. Lauren could not recall being told that she could seek support from her GP.

14.7.5 Brian was provided with verbal advice and information regarding accessing support for someone living with a family member with ASD. He was also given information about useful websites including The National Autistic

Society and Autism matters as they offer information and support. Brian stated that he was aware of these options and declined the offer of written information.

14.8 **What services did your service provide to Lauren?**

14.8.1 Both the high school and sixth form college attended by Lauren acknowledged the challenges that she faced because of Julie's health issues and put in place appropriate counselling and pastoral support.

14.8.2 Lauren attended her GP for routine medical appointments and attended at the local accident and emergency department for treatment to injuries consistent with her horse riding activity. There was no suspicion that her injuries were caused by anything other than the explanation given.

14.8.3 No other agency provided any services directly to Lauren.

14.9 **What knowledge or concerns did Julie and Brian's families, friends or employers have about their domestic abuse and did they know what to do with it?**

14.9.1 The panel has been unable to identify any friends of Julie's to engage with during the review. As mentioned at paragraph 13.1.4 Julie had not worked since 2011. Although Julie and Lauren attended and competed in many equestrian events, Lauren told the chair and author of the review that her mother did not easily make friends on the competition circuit.

14.9.2 Julie's mother declined to take part in the review. She did make a statement to the police which was read to the court during Brian's trial. The statement was broadly supportive of Brian and emphasised that Julie's behaviour could sometimes be difficult. Julie's mother said, *"Brian was an angel. I could not have wished for a better son-in-law or dad for Lauren."*

14.9.3 Although her family acknowledged that Julie's behaviour could sometimes present difficulties they did not give any evidence of domestic abuse.

14.10 **How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Julie and/or Brian?**

14.10.1 See section 11.

14.11 **Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Julie and/or Brian, or on your agency's ability to work effectively with other agencies?**

14.11.1 No agency has reported that issues with capacity or resources prevented them from working effectively in this case.

14.12 **What learning has emerged for your agency?**

14.12.1 The GP team discussed being more pro-active with questioning patients directly and more holistically in relation to domestic abuse. This would include any potentially vulnerable patient or family who are suffering with stress anxiety/ depression. An open question may be "how are things at home" or "how are the relationships within the family". Also, children who have parents with mental health issues need to be safeguarded and deeper questioning is required and a low threshold to refer to children's safeguarding team for support and assessment.

14.12.2 **NWBH** Since the murder of Julie, Warrington Mental Health Team have appointed an ASD specialist worker to support and guide staff, this has enabled further expertise within the Mental Health Team and ensures that someone presenting with autism symptoms can be assessed appropriately.

- Greater awareness of the dual diagnosis of ASD and Mental health needs
- 2 ASD specialist workers
- Closer working relationship with NWBH adult safeguarding team

14.12.3 Warrington/Halton Hospital recognition that there may be a domestic abuse issue with regard to Julie, possible opportunity missed to support Brian and Lauren, the comment above was not explored therefore not checking if Brian or Lauren were victims of domestic abuse.

14.13 **Are there any examples of outstanding or innovative practice arising from this case?**

14.13.1 Clinical Specialist for Additional Needs at CCC lead discussions with Lauren's Head Teacher, requesting that the school provide additional help and support for Lauren at this time due to her mother's recent cancer diagnosis and pending radiotherapy treatment plus Lauren was due to commence her GCSE studies.

14.13.2 An Alert was added to Julie's electronic patient record at CCC indicating that she had a diagnosis of Asperger's and her triggers are - not to be kept waiting and be specific with details/ information. This was seen as good practice.

14.13.3 Written information was provided by CCC to Brian and Lauren on local support services for carers, and for teenagers whose parents have mental health issues.

14.14 **Does the learning in this review appear in other domestic homicide reviews commissioned by Warrington Community Safety Partnership?**

14.14.1 Warrington Community Safety Partnership has completed two previous Domestic Homicide Reviews. The learning from them does not feature in this review.

15 CONCLUSIONS

15.1 The panel thought that the review distilled into 3 questions.

1. Were there any signs that Brian was going to murder Julie? No.
2. Was Lauren affected? Yes.
3. Were there any features that stopped the agencies from offering services? Yes.

15.2 The evidence in this case shows that Julie had suffered for a considerable number of years from different mental health issues and latterly with physical health problems including cancer. After losing her job in 2011 there appears to have been a gradual worsening of her conditions.

15.3 Julie was well supported by her local health services which she accessed on a frequent basis. It was noted by all the services that Julie was involved with that her husband Brian was a supportive and calming influence on her. Indeed, on numerous occasions when professions were having difficulties with Julie they would call him to assist. Brian would attend appointments with Julie or on her behalf if she was not well enough to attend.

15.4 When Julie was being treated for her physical health problems things did not always run smoothly. The evidence in this review highlights the difficulty in dealing with patients who are also suffering from certain mental health problems. The adverse effect in this case was that clinical procedures were delayed. Had Julie's mental health issues been known by all those dealing with her it should have been possible to plan and make the necessary adjustments to help her.

15.5 The focus of the care was quite rightly on Julie however, it has to be considered whether Brian's presentation as a professional, educated and articulate man had an influence on what support was offered to him and by association their daughter Lauren. The main exception to this would be the service provided by Clatterbridge Cancer Care NHS Trust.

15.6 During the time period under review Lauren was living in a household that was having to cope with difficult issues. It can be seen that she did well at school despite those difficulties. However, the fact that she was seen as coming from a reasonably well-off family with a professional father may have affected the decision-making processes of the agencies and professionals involved.

15.7 The panel discussed whether there could have been hidden abuse in the relationship that was not reported to agencies. The panel were aware of research which shows many victims of abuse do not seek help. For example, a Safelives report which shows;

'On average victims experience 50 incidents of abuse before getting effective help.'[11]

15.8 The review has however found no evidence that Julie was a victim of domestic abuse prior to her murder. The panel noted the sentencing Judge's comment that

You had had enough of her, saw the opportunity that presented itself that night to kill her and did so."

[11] SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives

16 LEARNING

16.1 Narrative

Brian presented as a calm, professional and articulate man during all his interactions with agencies. The family were seen as relatively well off. Lauren was doing well at school and Brian appeared to cope with all the prevailing circumstances. The picture painted to the outside world was not necessarily the reality of the situation.

Learning

Think Family[12]

The impact on Lauren of the family circumstances was not always understood by agencies who did not always think family.

16.2 Narrative

Health professionals who treated Julie for her physical conditions were not always made aware of her ASD diagnosis. This meant that on some occasions Julie's unexpected reactions to routine situations caused problems in healthcare settings and delayed her treatment

Learning

Professionals found it challenging dealing with Julie's behaviours as there was a general lack of knowledge about her autism. If there had been a better understanding by professionals then it may have been easier to make reasonable adjustments to assist Julie.

[12] The Think Family agenda recognises and promotes the importance of a whole-family approach which is built on the principles of 'Reaching out: think family'

17 RECOMMENDATIONS

DHR Panel

17.1 The Warrington CSP should seek assurance from its constituent agencies that practitioners have appropriate training in order to think family.

17.2 The Warrington CSP should signpost Agencies to the Social Care Institute for Excellence/ National Institute for Health and Care Excellence, guidance "Enabling positive lives for autistic adults". https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/enabling-positive-lives-for-autistic-adults

17.3 Single agency recommendations

17.3.1 Warrington Clinical Commissioning Group

As part of routine appointments for all patients all practices should consider asking the question, "how are things at home? Do you have any worries around coercion or control from others, either partners, family members or ex-partners?"

17.3.2 Warrington and Halton Teaching Hospitals NHS Foundation Trust

Increased domestic abuse training is recommended to ensure staff are aware of the importance of recognising domestic abuse. Lessons learnt to be shared trust wide via Safeguarding Committee.

Appendix A

No	Recommendation	Lead Agency	Date of Completion & Outcome
1	The Warrington CSP should seek assurance from its constituent agencies that practitioners have appropriate training in order to think family.	CSP	Action reviewed – Closed March 2021
2	The Warrington CSP should signpost Agencies to the Social Care Institute for Excellence, guidance "Enabling positive lives for autistic adults". Appendix B https://www.nice.org.uk/Media/Default/About/NICE-Communities/Social-care/quick-guides/enabling-positive-lives-for-autistic-adults-quick-guide.pdf	CSP	Action reviewed – Closed March 2021
3	**Warrington Clinical Commissioning Group** As part of routine appointments for all patients all practices should consider asking the question, "how are things at home? Do you have any worries around coercion or control from others, either partners, family members or ex-partners?"	CCG	Action reviewed – Closed March 2021

4	**Warrington and Halton Teaching Hospitals NHS Foundation Trust** Increased domestic abuse training is recommended to ensure staff are aware of the importance of recognising domestic abuse. Lessons learnt to be shared trust wide via Safeguarding Committee.	**Warrington and Halton Teaching Hospitals NHS Foundation Trust**	Action reviewed – Closed March 2021

End of overview report