Safer Lincolnshire Partnership

Domestic Homicide Review – Overview Report

The deaths of Louise and Grant

April 2017

Independent Author: Christine Graham

Preface

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The Safer Lincolnshire Partnership wishes, from the outset, to express their deepest sympathy to the sons and extended family. This review has been undertaken in order that lessons can be learned from this situation and we appreciate the support and challenge of the families with this process.

This review has been undertaken in an open and constructive way with all the agencies, both voluntary and statutory, entering into the process. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by Safer Lincolnshire Partnership on receiving notification of the deaths of Louise and Grant in circumstances which appeared to meet the criteria of Section 9(3) (a) of the Domestic Violence, Crime and Victims Act 2004.

The review considers the deaths of two victims. HM Coroner has held an inquest into Louise and Grant's deaths and recorded an open verdict in the case of Louise and suicide in relation to Grant. The police do not believe anyone else was involved in the death of Louise; this aspect will be explored later within this report.

Glossary

CBT	Cognitive Behaviour Therapy
DHR	Domestic Homicide Review
DWP	Department for Work and Pensions
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services
IMR	Individual Management Review
JTAI	Joint Targeted Area Inspection
LPFT	Lincolnshire Partnership NHS Foundation Trust
LSCB	Lincolnshire Safeguarding Children Board

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Section One – Introduction

1.1 Summary of circumstances leading to the Review

1.1.1 Just after mid-day early in April 2017 (day one)[1] East Midlands Ambulance Service received a 999 call, advising that a man had been found hanging. Whilst on the telephone to the caller, East Midlands Ambulance Service also received a call from the police as they were on route to the property.

1.1.2 On arriving at the property, the emergency services found that the man, now known to be Grant, was already deceased. He had been last seen by his youngest son late the previous night.

1.1.3 It quickly became apparent that there were concerns for the whereabouts of the man's wife, Louise, as she had not been seen for almost two weeks. Her sons believed that she had been staying with her friend, but enquiries quickly established that this was not the case and they had not been in recent contact. Louise's mobile phone and glasses had also been found in the home by the sons.

1.1.4 The police classified Louise as a high risk missing person, the house and outbuildings were secured, and a specialist search team began a systematic search the following day (day two). It was on day three that Louise's body was discovered in a rarely used ground floor store room. Her body had been concealed under wallpaper, cloths and laminate flooring.

1.1.5 The police began an investigation into the circumstances of both deaths. After a thorough investigation, there was no evidence to suggest that any third party was involved in the deaths of Louise and Grant. Whilst there is nothing to suggest that Grant's death was anything other than suicide, had he been alive, the police would have sought to question him about the circumstances of Louise's death.

1.1.6 A post mortem was undertaken, and whilst the cause of death could not be ascertained, the pathologist was able to determine that there was no evidence that she died from natural causes and the toxicology results did not indicate that she had taken anything that would have caused her death.

1.1.7 The Coroner has held an inquest into both deaths and has recorded suicide in the case of Grant and an open verdict in the case of Louise as the pathology results did not allow the cause of her death to be ascertained.

1.1.8 The Domestic Homicide Review Panel subsequently decided that this Review should consider the deaths of both Louise and Grant.

1.2 Reasons for conducting the Review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

[1] The pertinent dates have been numbered in order to assist with the chronology of events whilst maintaining anonymity

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case there is evidence of domestic abuse prior to both deaths. Therefore, the criteria for a review are met.

1.2.4 The purpose of the 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 policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to 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 possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.3 Process and timescales for the review

1.3.1 In April 2017 Safer Lincolnshire Partnership (SLP) was advised by Lincolnshire Constabulary that the death of Louise and Grant had occurred.

1.3.2 On 2nd May 2017 a partnership meeting was held chaired by the Chair of the SLP. The purpose of the meeting was to formally consider whether a DHR was appropriate in this case.

1.3.3 After due consideration of the circumstances that prevailed, a decision was made that a review would be held and that an independent chair would be appointed.

1.3.4 On 4th May 2017 the Home Office was advised of this decision.

1.3.5 On 5th September 2017 the Coroner was advised of the Domestic Homicide Review.

1.3.6 Christine Graham Consultancy Ltd was contracted to undertake the review. The review was chaired by Gary Goose supported by Christine Graham, who has written the overview report.

1.3.7 The Review Panel met for the first time on 17th July 2017. For the benefit of those involved in the review for the first time the process and purpose of the review was explained. The following organisations were represented at this meeting:

- Lincolnshire County Council
- Lincolnshire Police
- Representative of GP surgery
- United Lincolnshire Hospitals Trust
- South West Lincolnshire Clinical Commissioning Group
- East Midlands Ambulance Service
- The District Council
- Lincolnshire Partnership NHS Foundation Trust
- West Lindsey District Council (domestic abuse lead providing specialist knowledge)

Apologies were received from:

- Humberside, Lincolnshire, North Yorkshire Community Rehabilitation Company (HLNY CRC)[2]

1.3.8 At this first meeting, the Panel considered the composition of the Panel and it was agreed that, until the full chronology was complete, the Panel had the right members present.

1.3.9 Until the chronology was complete and it was known who had involvement with the family, IMRs could not be commissioned. Chronologies were requested from all agencies and this was extended to include Louise's employer and the Church of England.

1.3.10 It was agreed that additional information would be sought from family, friends and work colleagues.

1.3.11 The review concluded in April 2018.

1.4 Confidentiality

1.4.1 In order to protect the identity of the victim and her family members and the family of the perpetrator the following pseudonyms have been used:

Deceased Male: Grant
Female victim: Louise

Both were Asian British. They were married at the time of their deaths and had two sons.

[2] HLNY CRC has engaged in this review on behalf of what was Lincolnshire Probation Trust with the agreement of the National Probation Service

1.5 Dissemination

1.5.1 The following individuals/organisations will receive copies of this report:

- All the Review Panel members
- All partner agencies who are members of the Domestic Abuse Strategic Management Board
- The family who are subject of the review

1.6 Terms of reference

1.6.1 The terms of reference were agreed by the Review Panel on 11th September 2017 subject to any further questions being raised by the family. This was not the case.

Terms of Reference for the Domestic Homicide Review into the death of Louise

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Safer Lincolnshire Partnership (SLP) in response to the death of Louise on 7th April 2017.

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the SLP has appointed Gary Goose to undertake the role of Independent Chair and Christine Graham as the Overview Author for the purposes of this review. Gary and Christine will work together to undertake the investigatory work. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2. Purpose of the review

The purpose of the review is to:

2.1 Establish the facts that led to the incident on 7th April 2017 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

2.3 Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on 7th April 2017; suggesting changes and/or identifying good practice where appropriate.

2.4 Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

3. The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2013).

3.2 This review will be cognisant of, and consult with, any on-going criminal justice investigation and the process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

4. Scope of the review

The review will:

4.1 Seek to establish whether the events of 7th April 2017 could have been reasonably predicted or prevented.

4.2 Consider the period from 1st January 2007 (when they moved to the area), subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

4.3 Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.4 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

4.5 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and make any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

4.6 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,

- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5. Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6. Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the SLP or the Review Panel require legal advice then Safer Lincolnshire Partnership will be the first point of contact.

7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.

1.7 Methodology

1.7.1 Safer Lincolnshire Partnership was advised of the deaths by Lincolnshire Police early in April 2017. This was by way of a letter from the Assistant Chief Constable. This was a timely notification and demonstrated a good understanding by the police of the need for a referral at the earliest opportunity.

1.7.2 As a result of the notification, a partnership meeting was held on 2nd May 2017. This was chaired by the Chair of the Safer Lincolnshire Partnership.

1.7.3 Having heard the details of the case, it was agreed that the criteria had been met and that a review would be held.

1.7.4 Gary Goose and Christine Graham were appointed to carry out the review. The Review Panel met for the first time on 17th July 2017. At this meeting, it was agreed that the chronology would be compiled.

1.7.5 Information from records used in this Review was examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.7.6 The Panel met again on 11th September to review the information held by agencies and consider if other agencies should be invited to join the Review Panel. It was agreed to invite Children's Services and Citizens Advice Bureau. The panel considered the need for specialist input. It was agreed that the domestic abuse lead of West Lindsey District Council would provide expertise around domestic abuse, it was also agreed that there was need to understand the implications of the family's cultural background. Christine Graham agreed to speak to a person she knew who could provide this expertise. Whilst this person did not join the panel, two in depth discussions were held with her and this has been referenced in the report.

1.7. 7 When the panel met on 9th November 2017, Gary and Christine provided full feedback about meetings that had been held with family and friends and the insights that this had provided. The chronology was considered and IMRs were commissioned.

1.7. 8 IMRs or written reports were requested from:

- Lincolnshire Police
- Lincolnshire Probation
- West Yorkshire Police
- GP
- Lincolnshire County Council Children's Services
- Lincolnshire Partnership NHS Foundation Trust
- The District Council
- Queen Elizabeth Hospital
- Women's Aid
- School where Louise worked
- Church of England
- Citizen's Advice Bureau
- College of West Anglia (where Grant had been enrolled on a course)
- Department for Work and Pensions
- Compass Point Business Services (providing front and back office services for The District Council

1.7.9 The panel met on 7th February 2018 to consider the IMRs that had been prepared. The content of these will be discussed later in the report.

1.7. 10 The Chair and Report Author have met regularly with the family and have kept them informed about the progress of the report. The surviving sons were informed about AADFA and the support that they could provide at the first meeting with them. Although they did not take up this opportunity at this point, they were reminded on a number of occasions about the organisation and, towards the end of the review, they did make

contact and received specialist support which has been of great value to them. They were offered the opportunity to meet with the review panel but did not wish to do so. Meetings have also been held with the work colleagues of Louise, their local vicar and close friends. The content of these meetings is woven throughout the report.

1.7.11 Through the police, the Chair and Report Author also tried to meet with two fellow students of Grant who had information relating to the days leading up to the deaths that may have been important to assist in understanding his state of mind. They, however, did not wish to engage with the review and this position is totally understood.

1.7.12 The Chair and Report Author would like to thank the family and friends of Grant and Louise for their willingness to engage with the review. Their contributions have been invaluable in understanding the family circumstances.

1.7.13 The review's active inquiries concluded in February 2018. The report was completed in March 2018 with a final panel meeting on 24th April 2018.

1.8 Equality and Diversity

1.8.1 During the review, it has become very clear that the cultural background of Louise and Grant played a significant part in their marriage and family life. The Chair and Report Author have sought to understand the part that this has played, and this is explored at different points throughout the report.

1.9 Contributors to the review

1.9.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

1.9.2 All Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, was made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.9.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the panel or meeting for an interview.

1.9.4 The following agencies and organisations contributed to the review:

- Addaction
- BetelUK
- Boston Women's Aid
- Citizens' Advice Bureau
- College of West Anglia
- East Midlands Ambulance Service
- Employer of Louise
- GP for the family

- Lincolnshire County Council, Children's Services
- Lincolnshire County Council, Safer Communities
- Lincolnshire Police
- Lincolnshire Probation
- Lincolnshire Partnership NHS Foundation Trust
- Queen Elizabeth Hospital
- The District Council
- South West Lincolnshire Clinical Commissioning Group
- United Lincolnshire Hospitals Trust
- West Lindsey District Council
- West Yorkshire Police

1.9.5 The following individuals contributed to the review:

- Louise and Grant's sons
- Sister to Grant and cousin to Louise
- Close friends of Louise and Grant
- Local vicar
- Expert in cultural/domestic abuse issues

1.10 The Review Panel

1.10 The members of the DHR Panel were:

Natasha Swift	Addaction
Julie Lyon	Citizens' Advice Bureau
Paul O'Shea	College of West Anglia
Debbie Johnson	Diocese of Lincoln
Zoe Rodger-Fox	East Midlands Ambulance Service
Dr Hossany	GP for family[3]
Head Teacher	School employer
Claire Tozer	Lincolnshire Clinical Commissioning Group
Roz Cordy	Lincolnshire County Council, Children's Services
John O'Connor	Lincolnshire County Council, Education
Liz Bainbridge	Lincolnshire Partnership NHS Foundation Trust
Ron Jackson	Lincolnshire Police
Sarah Norburn	Lincolnshire Police
Kim Plant	Probation CRC
Kay Crome	Queen Elizabeth Hospital, Kings Lynn
Emily Holmes	The District Council
Sarah Smith	South Lincolnshire Domestic Abuse Services
Emma Waters	West Lindsey District Council (domestic abuse expert to panel)
Allan Raw	West Yorkshire Police

[3] The name of the GP has not been included to protect the anonymity of the family

1.11 Domestic Homicide Review Chair and Report Author

1.11.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary has been employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.11.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. Christine also delivers Partnership Health checks which provide an independent view of partnership arrangements. Christine is also a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews.

1.11.3 Gary, working alone, has completed six Domestic Homicide Reviews (as Chair and Report Author). Working together, Christine and Gary are involved with eleven reviews (one of which is complete).

1.11.4 Neither Gary Goose nor Christine Graham are or have been at any point in the past associated with any of the agencies involved in the review.[4]

1.11.5 Both Christine and Gary have:

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports
- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended the AAFDA Annual Conference (March 2017 and March 2018)
- Attended training on the statutory guidance update in 2016
- Undertaken Home Office approved training in April/May 2017

1.12 Parallel Reviews

1.12.1 The coronial process is now complete and there are no other reviews being undertaken.

[4] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36 page 12), Home Office, December 2016

Section Two – The Facts

2.1 Introduction

2.1.1 Both Louise and Grant were born in Pakistan. They would be classified as British Asian. Grant had lived in the UK for much of his life whilst Louise moved here when they were married approximately 30 years ago. They had two children who are young adults. Grant and Louise followed the Christian faith.

2.1.2 Louise and Grant lived their early married years in London and moved to Lincolnshire in 2005. It has not been fully established why they moved to rural Lincolnshire. At the time they moved to the area, Grant worked in IT in London. Louise worked as a learning mentor, later training to become a qualified teacher (a profession she had held in Pakistan). They were very active in the village, particularly Louise who was very involved in the local church.

2.1.3 At different points over the years, they came to the attention of the police and other agencies and this will be explored in the chronology which will follow. At the time of his death, Grant had three impending prosecutions, all relating to driving whilst under the influence of alcohol.

2.2 Chronology

2.2.1 Background information

2.2.2 Grant, who was 49 years old at the time of his death, had moved to the UK when he was six or seven years old. He had a background of working in IT but had experienced a number of periods of unemployment since moving to Lincolnshire and during this time Louise had become the main wage earner. Grant had problems with alcoholism that had existed for a number of years.

2.2.3 Louise was 50 years old at the time of her death. She had moved to the UK in her twenties when she married Grant. They were first cousins. She worked as a teaching assistant in a local school and had recently qualified as a teacher. She was very active in the local church and faith played an important part in her life.

2.2.4 For a period of time (the exact details of which remain unclear) up to her death in March 2016, Grant's mother lived with them in the family home, contributing significantly to the family finances. Her death resulted in the couple falling into financial difficulty.

2.2.5 Grant was described as a man who struggled with alcohol and when he was in drink he became a different man. He was very charismatic and described as loving and caring when sober but when drunk he became 'loud and lary' and aggressive.

2.2.6 Louise was described as a loving mother.

2.2.7 Louise and Grant were first cousins but, in their culture, despite them following the Christian faith, interfamilial marriages were not uncommon. It was known within the

family that Grant had a problem with alcohol. It has been reported to this Review that Grant had not initially wanted to marry Louise, preferring Western women; however, once she became pregnant they did marry. The information placed before this review suggests that Louise was aware of his behaviour and married him for love, not simply because she was pregnant.

2.3 Detailed chronology from 1st January 2011 to 7th April 2017

2.3.1 The time prior to 1st January 2011

2.3.1.1 Whilst this Review asked that IMRs be prepared from the period from 1st January 2011, there are some pertinent events prior to this time that are included here in order to aid the understanding of this case.

2.3.1.2 This Review has learned that in his early days, Grant worked for a large dental practice in London and had access to cocaine (as a form of it was used for pain relief). He became involved in a social circle with a prevalence of drugs and alcohol and it was here that he began to use cocaine and alcohol. Grant enjoyed that lifestyle and the 'nice things' that this brought with it. He was described as someone who was dazzled by the life-style of the big city.

2.3.1.3 Just before Christmas 2005, the family moved to Lincolnshire and began attending the local parish church. At this time, Grant had a demanding job in IT, still based in London. Shortly after the family moved to Lincolnshire, Grant lost his job. He was a man who, not only wanted to provide for his family, but enjoyed the status that his job in London had afforded him. He had a number of consultancy jobs, but he always lost these jobs. At the beginning of May 2007, Louise began work as a learning mentor.

2.3.1.4 There were two incidents, in April and May 2007, when Grant came to the attention of the police. The first related to a driving offence. Grant was arrested and later convicted of failing to stop after an accident. He was fined and disqualified from driving for 12 months. The second relates to an intelligence report submitted by the police in Bradford when Grant was seen appearing to be looking for business in the red-light area. He was spoken to about the area and about his behaviour around women. In May 2007, Grant's GP referred him to Addaction. He was then arrested in June for being drunk in charge of a vehicle after being found heavily intoxicated behind the wheel of a parked car. He later failed a breath test specimen. He was fined, and he received more penalty points.

2.3.1.5 Grant had no further contact with the police until 4th December 2009, when he was arrested after providing a positive breath test whilst driving. He was disqualified from driving for 40 months.

2.3.1.6 In 2009 Louise became a church warden at a local church. This is an important role in the church, governed by ecclesiastical law, which involved her providing advice and pastoral support as well as being responsible for the physical maintenance of the church building. This was a role to which she had been elected so was obviously trusted and well-liked by those within the church family.

2.3.1.7 In February 2010, the couple's GP was asked for a reference in relation to a foster parent application by Grant and Louise. This is not mentioned by any family or friends and therefore it was probably not widely known. His cocaine and alcohol use were disclosed as part of this process. They did not go on to foster.

2.3.2 **2011 onwards**

2.3.2.1 In April 2011, Louise made a 999 call to the police to report that Grant was in drink, a verbal altercation had occurred, and he had pulled her hair and grabbed her arm, twisting it up her back, causing pain. When officers attended Grant was arrested. Louise disclosed that this was the first time in 18 years of marriage that he had assaulted her, and she put it down to him losing his highly paid job in London causing him financial stress and to turn to alcohol. Whilst she provided a statement to the police, she did not support a prosecution against him and did not wish for him to go to court. He received a police caution and a referral was made to the police Public Protection Unit.

2.3.2.2 There are a number of police intelligence items in April 2011 relating to Grant regularly drinking and driving whilst disqualified.

2.3.2.3 In July 2011, Louise made a 999 call to request that the police attend the address. She sounded distressed and said something about her husband to the operator but then she terminated the call. Police attended and spoke to both Grant and Louise and they said that only a verbal argument had taken place. Although Grant had been drinking heavily Louise said she had not been assaulted. Grant was removed from the premises to stay with a friend and no further action was taken.

2.3.2.4 In October 2011, a report was received from the ambulance service stating that a man had been found unconscious, possibly in drink, slumped over the steering wheel of a car in a Lincolnshire village. The man was, according to the ambulance service, aggressive and refusing treatment. The fire and rescue service were also in attendance and reported that there were different fuels stored in the car. Police officers attended and arrested Grant after he had provided a positive breath test. He received a suspended prison sentence, was disqualified from driving for 48 months and was ordered to complete 300 hours of unpaid work.

2.3.2.5 Towards the end of 2011, Grant's drinking became more of a problem and Louise felt she had to step back from the role of church warden.

2.3.2.6 Also, around this time, Louise approached the head-teacher at the school where she was working to ask if the school was able to lend her some money. She said that Grant had lost his job due to his drinking and they were struggling financially, and she feared they would lose the house. It was explained to her that this was not possible, but she was provided with details of agencies that might be able to help her. The head-teacher checked regularly with Louise and she said that things had improved, and they were looking to sell/rent land on their property to help.

2.3.3 **2012**

2.3.3.1 In February 2012, Louise telephoned Children's Services to ask for the telephone number of a refuge. She said that her husband was an alcoholic, and she could not cope anymore. She said he had been physically abusive in the past and the police had been called. When asked what had happened that night which made her want to leave, she said that he had been drinking and they had an argument during which he had pulled her hair. When she had said she would call the police, he had laughed. She also said that he was not working, and they had received a notice for repossession on the property. She would not leave a number and said she would call again the next day and was advised to call housing.

2.3.3.2 The next day, Louise contacted the Housing Advice service at The District Council. In this call, she explained that the relationship had been on and off for the past four years, but things had got worse since January when Grant lost his job. During this conversation, details of their financial situation were recorded. Louise stressed that she did not want to flee the area and wanted to remain local.

2.3.3.3 Louise was offered a room by Women's Aid, but she declined this saying she had found private rented accommodation and was advised by Housing Advice that she was not eligible for Bond Assistance. We know that during this time, Louise was not attending work due to illness.

2.3.3.4 In late February, probation completed a Pre-Sentence Report in relation to Grant's offences of driving with excess alcohol whilst disqualified. The proposal to the court was for a 'stand-alone' community order with an unpaid work requirement.

2.3.3.5 Grant appeared in court on 28th February and was sentenced to a 12 month Suspended Sentence Order with an unpaid work requirement of 300 hours.

2.3.3.6 The same day, Louise attended the Women's Aid drop-in office in Boston. She disclosed that there had been domestic abuse for many years; there had been physical incidents and a history of violent behaviour by her husband. She described how he drank daily, and this made matters worse and he had lost many jobs over the years. Louise was advised about a number of different options open to her including accessing a refuge place in Boston. The risk to her and her boys was assessed, at this point, as low risk. She left the office saying she would be in contact once she had been able to think about her options. She indicated that it was not safe to call her at home and did not want contact at school as she did not want her colleagues to know what was happening.

2.3.3.7 We know that during this time, Louise was not at work due to illness.

2.3.3.8 A week later, in early March 2012, Louise contacted Women's Aid again and said she was worried that they were going to lose their house. She again stated that she did not wish to go into a refuge because the boys were doing their exams.

2.3.3.9 Two days later, Louise contacted Housing Advice as she had received a letter from the mortgage company saying they were applying to repossess the house as they had missed two monthly payments and had breached the SPO. She was given advice about explaining to the court that she had two children and to request the maximum notice period. She

was also advised about housing legislation and private rented options. Louise would not leave her phone number and said she would call back.

2.3.3.10 The same day a 999 call was received from a member of Grant's family. It was reported that the relative had spoken to him on the phone and he had intimated that he would commit suicide; that he had a history of depression and was not now answering his phone. Officers attended and saw Grant who was heavily in drink but appeared stable and said he had not consumed any alcohol. He was furious that the police had been called and refused any treatment. Louise was contacted at work and she went home to look after him.

2.3.3.11 As a result, his GP referred him to Lincolnshire Partnership NHS Foundation Trust (LPFT). The referral stated that he had taken to his bed with suicidal thoughts; he was not complying with his diabetic medication and was consuming large amounts of alcohol. That same day, LPFT contacted Grant and spoke to Louise who explained the problems they had been experiencing. She told them that she did not think that Grant knew that the referral had been made.

2.3.3.12 The next day, LPFT called Grant to arrange a home visit for assessment. He was surprised to hear from them and said he did not know why they were calling. He did not appear to wish to engage and said he would call them back to arrange the assessment. As he did not call back, LPFT rang again and he did agree to an assessment within a couple of days, but he appeared reluctant to engage.

2.3.3.13 On the day of the assessment, LPFT needed to rearrange the home visit to three days later. On this day, Grant also attended Addaction for an assessment, following a telephone referral made by Louise. At this assessment, he reported that he had begun drinking 1 litre bottle of vodka whilst the children were at school. He had been made redundant two months earlier and was feeling very low. Although he was worried about finances, he had two interviews in the coming weeks. He reported that he had admitted himself into the Priory previously[5] and had attended an AA meeting the previous day. Although he did not agree with their 12-step programme, he could see the benefit of the meetings and would continue to attend. He said that his aim was to be able to drink socially at weekends.

2.3.3.14 Grant was seen by LPFT at home for an assessment in mid-March. He told them that his only problem was with alcohol and had no suicidal ideation. He said he had stopped drinking and had visited Addaction and AA. He had spoken to all his debtors and advised them of his employment status, but he had two interviews and had been offered both jobs which meant he was now in a position to sort out his finances. The assessment concluded that he had no mental disorder or requirement for further contact from LPFT. He was discharged.

2.3.3.15 In April 2012 Lincolnshire Police were contacted by the Metropolitan Police who had in turn been contacted by a friend of Grant. He had received a call from Grant which suggested he was contemplating suicide, so he had called the police. Officers attended the home address and, after forcing entry, could not locate Grant. He then emerged from an outbuilding and had clearly been drinking and officers believed he was trying to avoid

[5] The review has no further details about this interaction

them. When he was advised of the reason for their attendance he told officers he often made silly calls when drunk and he was not suicidal.

2.3.3.16 There are a number of police intelligence items in April 2012 relating to Grant regularly drinking and driving whilst disqualified.

2.3.3.17 In early May 2012, Boston Women's Aid closed their case as they were not able to make contact with Louise.

2.3.3.18 On 8th May 2012 Louise made a 999 call to the police reporting that her husband was an alcoholic, that he was in drink and they were verbally arguing about his drinking. She told the police that he had not been physically violent, was now in bed and she was leaving to go to work. When officers saw her, she said he had been drinking increasingly due to losing his job and the financial implications were putting a strain on their relationship. She said that she was due to start a new job in the next week and that this would help with their financial and relationship problems. A DASH risk assessment was completed and was graded as 'standard'. The officer reported that there were always verbal arguments and nothing physical. The children were not present when the incident occurred.

2.3.3.19 In June 2012, Louise contacted Housing Advice to tell them she had an eviction warrant for early July 2012. When advice was given about making a housing application, Louise stated that she did not want Grant to be included, but she did want her mother-in-law to be included. She also said that Grant had been in full time employment for three weeks. Louise visited the office later that day to complete the necessary forms. Over the next few days, housing officers sought to find suitable rented accommodation for Louise but when they phoned her on 28th June she said she was hopeful that, when she attended court on 29th June, the eviction would be suspended, and they could put the house on the market. On 2nd July, she did advise that the warrant had been suspended and was given information about a potential rented property.

2.3.3.20 On 2nd July, after making numerous attempts since the end of March to contact Grant to arrange a follow up appointment, Addaction closed the case.

2.3.3.21 In July, Louise informed Housing Advice that Grant had lost his job and so they would not now be able to make the mortgage payments. She said there had been another big argument the day before.

2.3.3.22 In mid-August a call was received by the police from a member of the public reporting that she had seen a male driving who she believed had no licence. Whilst the details provided suggested that this seemed to relate to Grant, there were no other positive sightings of him driving on this occasion, so no further action was taken.

2.3.3.23 In September 2012, Louise began her foundation degree to become a qualified teacher.

2.3.3.24 Also in September 2012, a female made an anonymous call to the police to report that she had seen Grant driving while disqualified and said he might be under the influence of alcohol. He was not located on this occasion.

2.3.3.25 On 25th September, Housing Advice wrote to Louise advising her that, as she had not been in contact, her housing application had been cancelled.

2.3.3.26 In late November 2012, Grant attended court and the unpaid work requirement of his order was removed on medical grounds and replaced with a 4-month curfew. There was now no involvement with Probation Services.

2.3.3.27 On 24th December 2012, Louise attended the Women's Aid outreach office. She discussed seeking legal advice, accessing the rent deposit scheme and obtaining a place in refuge. She was offered a place in Boston. At the end of the meeting, she said she needed to go and think about her options. She was not able to provide safe contact details and safety planning was discussed with her.

2.3.3.28 It is also known that at some point in 2012, Louise had a conversation with her vicar in whom she mentioned briefly that Grant was drinking again, and he had been behaving violently. He asked her if she was OK and safe and she said she would tell the police if it happened again. The vicar told her about cards at the back of the church which provided useful numbers of agencies that might be able to help her. Whilst he did not follow up specifically about the violence, he continued, over the years, to provide pastoral support.

2.3.3.29 During 2012 and 2013 Louise saw her vicar more often for pastoral support. He said that she was increasingly worried about her home situation, but she never again expressed concern about violence at home and there were never any signs of physical abuse.

2.3.4 **2013**

2.3.4.1 The vicar said that during 2013/14 Louise was struggling to cope as Grant had hit rock bottom. She needed a period of separation and moved out for a time. By this time, Grant's mother was living with them and this seemed to provide some stability in the home. Grant had been through a period of rehabilitation and was looking for work. The local vicar articulated that he did what he could to introduce him to potential employers but, as he said, 'his history seemed to catch up with him'. Whilst at the time he thought this was his alcoholism and depression we might now consider that what actually happened was that they found out about his criminal convictions which the vicar was not aware of.

2.3.4.2 In early January 2013, a 999 call was received by the police from Louise who reported that she had a problem with her husband who was in drink and had been violent. She was tearful and stated that he had not been violent on that day, but it was a verbal argument about his drinking. She told the police that she did not want him to be there when the children came home from school. Officers attended and although was in drink and being awkward he was reported as not causing major problems and he agreed to go to bed and sleep it off. Louise was advised to seek help for her husband. A DASH risk assessment was completed and rated as 'medium' having been cross-referenced to the incident of May 2012. Louise told the officer that she was frightened of Grant when he was drinking and that the abuse was happening more often. Grant had, it was reported, been sober for months but was now drinking again after Christmas.

2.3.4.3 Later in January 2013, Grant pleaded guilty at court to failing to comply with a suspended sentence supervision order between 28th February 2012 and 21st December 2012. The court decided that the order should continue.

2.3.4.4 In April 2013, Grant reported the theft of his car from the driveway of his home. At the time of the call, he appeared vague, was slurring his words and may have been in drink. When officers attended, Louise said he was in bed and she did not want him waking. The car was later located on a steep bank and a recovery vehicle was needed to retrieve it. Officers found a bottle of vodka in the foot-well. There was no damage to the ignition barrel and officers suspected that the vehicle had not, in fact, been stolen. Grant was spoken to again and he was very vague about the circumstances and said he did not know how the car had got to the location where it was found, but he admitted the vehicle had not been stolen. He was advised about wasting police time and potentially driving whilst disqualified.

2.3.4.5 In September 2013, Grant called the Housing Advice for general advice about the Mortgage Rescue Scheme. He was advised that this was no longer available in the area but was given advice about Mortgage Interest Payment from DWP. He was advised about the help that CAB could provide, and a referral was made to them. He was advised to apply for a variation order, contact his lender and put the property on the market, as well as seeking independent legal advice (an email from CAB in late October indicates that he did not attend the appointment that had been made for him).

2.3.4.6 In mid-October, Grant saw his GP and advised him that he was binge drinking again, a bottle of vodka a day for the last 8 days. He said he was feeling down and not sleeping or eating, and antidepressants were prescribed.

2.3.4.7 At the end of October, Grant told his GP that he'd had two weeks without drinking but was now drinking again. When he saw the GP again in late November, he said that the antidepressants were having no effect, he did not feel any different and although he was drinking he was not dependent and could stop at any time. In early December he was referred by his GP, for counselling and it was agreed he would go for an assessment in January 2014.

2.3.4.8 In December 2013, Housing Advice had not heard from Grant following his contact in September, so a courtesy call was made. He was 'irate' about the receiving the call and said he had no issues and did not need any help. However, he did not want the case closed. When it was explained to him that they were calling in relation to Housing Advice not a housing application he hung up.

2.3.4.9 In December, Grant's GP wrote to LPFT to make a referral for improving access to psychological therapies.

2.3.4.10 Also in early December, Louise made a 999 call to the police reporting that her husband had forced his way into the property and was refusing to leave. She had locked the door because he was drunk and told him to come back when he was sober. He had, however, broken the door down to gain entry and was being verbally abusive to her. She said he had been drinking vodka all day and she was keeping possession of the car keys so that he could not leave in it. Louise told the police that the children were not present. They had

been present on the previous day when he had started to argue with them but had calmed down when spoken to by his mother. When the police arrived, she told them that he had been drinking vodka all day and when he had gone outside to get more she had locked him out of the house, but he had broken the window in the door with a shovel. She would not make a statement but said she wanted him out of the house. Grant was heavily intoxicated and was arrested to prevent a breach of the peace. Upon arrival at the police station he said 'she's gonna fucking regret this'. When he sobered up he was very remorseful and embarrassed. He was released from custody and taken home. Whilst they were at the address officers noticed an air rifle which was seized for safe keeping. A DASH risk assessment was completed and was graded 'medium'.

2.3.4.11 The following day, Louise made a further 999 call to the police. She said that Grant had arrived home after drinking and was trying to force his way in to the house. She said he had been pushing her around and had shoved her through an open doorway. Officers attended and arrested him for common assault. A DASH risk assessment was completed and graded as 'medium'. She said that she had tried, three times in the past year, to separate from him but he kept promising to stop drinking. On this occasion, she reported that he had pulled the hair of one of the children and had, on previous occasions, punched and slapped the children. She said that he was drinking and arguing more, and that the problem was escalating. She said he was now drinking from dawn to dusk. He subsequently pleaded guilty to the offence of battery and received a supervised community order which lasted until January 2015, together with a requirement to attend an alcohol treatment programme. During the time of these incidents, Louise did not attend work due to illness.

2.3.4.12 In mid-December, Louise contacted South Holland District Council to advise them that Grant had left their home again.

2.3.4.13 The local authority's Children's Services team received information regarding the incident from earlier in December. As this was the third notification they had received in a year, it was passed to the team for assessment. It was then allocated to a social worker and a visit to the home was planned for 23rd December. At this meeting, a safety plan was put in place for Christmas.

2.3.4.14 In late December, Grant contacted Housing Advice to say that he had been removed from the marital home on 18th December by the police. He had been told not to return and had been staying with family and friends since then. He advised that, although he had not been asked to leave where he was currently staying he did not feel he could stay there any longer. He was told that it was unlikely that he would be a priority need and was given information about bed and breakfast places. He was told he may be eligible for housing benefit and was invited to a detailed assessment on 30th December 2013.

2.3.4.15 On 30th December, Housing Advice was notified by Framework[6] that Grant had self-referred into them over the weekend. He had said he was at risk of rough sleeping but was currently sofa surfing.

[6] Support service for homeless and vulnerable people in Lincolnshire

2.3.4.16 At some point during 2013, Louise stood down from her role as a Church Warden as she told the vicar she needed to concentrate on finding work. The vicar remembers many conversations over this time with Louise about her worries for Grant in relation to his low mood and alcohol use. He advised her that she should seek medical help for him. During this time, Louise did not attend church so regularly and it was thought she was attending church elsewhere, but she did continue to be involved with the prayer group at her local parish church.

2.3.4.17 The vicar has also reported significant events which appear to have occurred during 2013 which the review has not been able to put an exact time to. At some point during the year, Louise left the family home saying she needed some space in her marriage and, at another point during the year, Grant moved into a flat outside of the village. At another point in the year, Grant was pleading with her to come back and she needed financial support for him to go to a rehabilitation centre. This did not meet the criteria for the charity attached to the church, but the vicar used some money from his discretionary fund to support this.

2.3.5 **2014**

2.3.5.1 In January 2014, Grant was spoken to over the phone by LPFT for a clinical and risk assessment. The assessment indicated that his main problem was depression and low self-esteem with low motivation. He was referred to a stress management course for psycho-education socialisation to model and gain skills and strategies to manage current difficulties. The five-session programme was due to begin later in January and he attended this first session.

2.3.5.2 Also in January, Louise and her son were visited by a social worker at the home.

2.3.5.3 In late January, Grant appeared in court charged with common assault. He was sentenced to a 12-month community order with supervision requirement, an alcohol requirement and a specified activity requirement of 10 days.

2.3.5.4 Grant arrived 40 minutes late for his appointment with Addaction in late January. He smelt of alcohol but denied having had more than two drinks that day. He also reported only one drinking day in the last four. It was therefore agreed that the assessment would be undertaken. During this, he disclosed that he can go weeks without a drink and then go on a three-day binge, consuming a litre of vodka a day. He said that he will drink whilst the family are out, stopping before they come home although he realises they are aware of this.

2.3.5.5 In February he was seen again by Addaction and reported to have been abstinent for four weeks. He said he was now living back with his wife and children, but he wondered if it would be better if they split up. He was keen to get back into work and had an interview for an IT Business Manager position.

2.3.5.6 Grant was due to attend the third stress management session in February, but he cancelled this session. He did not attend any further sessions so was discharged back to his GP in April.

2.3.5.7 In late February, Grant met with his probation officer and a full assessment was undertaken. He was assessed as presenting medium risk of serious harm to a known adult (Louise) and his children.

2.3.5.8 In March Children's Services advised probation that they were closing the case.

2.3.5.9 Grant did not attend his appointment in late April with Addaction.

2.3.5.10 In May he entered rehabilitation with BetelUK.

2.3.5.11 On 2nd June 2014, Grant discharged himself from BetelUK and went home. They would have expected him to stay for 12-18 months but he left after a month. During his time at BetelUK he would have undergone a 1-1 withdrawal programme which would be followed by other work to address the underlying causes of his drinking. Once he left, he was linked back into probation for caretaking.

2.3.5.12 In June Grant was seen by probation. Concerns were raised about his honesty about his level of drinking and he was reminded about his order.

2.3.5.13 In June, Louise was interviewed by Compass Point Business Services (who provide front and back office services on behalf of The District Council) about undeclared jobs that her husband had and whether he was living in the family home. She was offered, and accepted, a formal caution in respect of her application, in lieu of prosecution.

2.3.5.14 In September Louise moved to another primary school as a teaching assistant.

2.3.5.15 During 2014, Louise was not attending the local parish church, so the vicar did not see them other than in passing in the village. However, he does recall seeing Grant after he had attended the rehabilitation programme and he seemed a 'changed man'. He had invited the vicar to visit the home which he did, and the vicar observed that they were all living together and appeared to be doing well.

2.3.6 **2015**

2.3.6.1 In January 2015, Grant's Alcohol Treatment Order expired, and probation reported that, following his time at BetelUK, he had attended regular appointments and supervision appointments. He continued to report that he had not been drinking alcohol since leaving BetelUK and was focused on gaining employment.

2.3.6.2 In early February, Grant told his GP that he was having CBT which he was finding very useful, although the review was not able to establish where Grant accessed this intervention. At this time, he also requested another certificate. In April he was continuing to tell his GP that he did not feel ready to return to work.

2.3.6.3 Grant started his business degree in September 2015, studying at a local college. This was a full-time course.

2.3.6.4 In November 2015, Grant was described by his GP as not being ready for work. A phased return was discussed with him. Grant was expecting to hear from DWP about an interview to discuss his fitness to work.

2016

2.3.7.1 In April 2016, Louise visited a nurse practitioner and said she was feeling down and depressed. She had, for a few days, been struggling to fall asleep and concentrate. When she returned to the GP in May, she reported she was occasionally weepy and had mood swings. The GP had a long chat with her and she was not keen to take anti-depressants. She reported that her appetite and sleeping were both OK.

2.3.7.2 In September, Grant's GP was advised that he was now considered capable of work.

2.3.7.3 At some point in 2016, it is thought that a close friend of Grant and Louise had committed suicide. A number of people referred to this having affected Grant particularly, and it bringing into sharp focus for Louise about his depression. At one point, she had to leave work during the day to take him to the doctors as she was concerned he would not go otherwise.

2.3.7.4 In February the police were contacted by a local car dealership. Grant had, over a period of months, borrowed vehicles under the premise that he was looking to swap his lease vehicles. Through investigation the police found that he had done the same at various dealerships in the area.

2.3.7.5 In December 2016, a car dealership reported that they had loaned Grant a vehicle for four days at the end of November. After two weeks, he had not returned the vehicle and, not being able to contact him, they visited his address. Whilst there was no reply to their knocking, they could see their car with the keys inside and so they recovered the car. Whilst the car was in Grant's possession, the dealership alleged that £2,000 of damage had been caused to the car not, in their view, due to an accident but by being vandalised.

2017

2.3.8.1 At the beginning of January 2017, Louise qualified as a teacher and began her first teaching post and it is around this time that there is evidence that things became very difficult. This was referenced by both friends and colleagues of Louise. A number of people talk about Louise losing a lot of weight[7] and she seemed pre-occupied. Whilst some friends suspected they were in debt, others could not get her to talk about what the root of the problems were. She became distant, forgetful and was not taking things in and was not focused.

2.3.8.2 This Review has learned that, during this time Louise spoke to some very close friends about how finances were difficult. A number of friends and colleagues lent Louise money or gave her food. It is now known that the couple were in significant debt and the only source of income was Louise's salary. The financial situation seems to have worsened following the death of Grant's mother and the loss of her pension. Repossession

[7] Although no medical explanation can be found to support or explain this

proceedings had begun on the property with a letter from HM Courts and Tribunal Service having been received five days before we believe Louise died. There was a period of time when he would ring her at work a number of times each day. Although the school were firm that she was teaching he was adamant that it was urgent, and he needed to speak to her. We do not know the content of those conversations as they always spoke in their native tongue.

2.3.8.3 On 7th March, Grant was described as 'a bit argumentative' in class, questioning the relevance of research they were being asked to carry out. He complained that the course was too theoretical and wasn't relevant. He was challenged by the lecturer about his behaviour and got on with the work but did not seem particularly focused. This was deemed to be out of character and the lecturer decided to keep an eye on him over the next week. Later this same day, a report was made that Grant had been 'leering' at students on another course and was heard making inappropriate sexual comments to other students on his course. When he was told by a fellow student to stop trying to chat up these students, he did. This matter was raised with Grant in a conversation on 14th March when he was asked by his tutor if he was OK. He apologised for his behaviour the previous week, saying he had 'stuff going on' and assured them it would not happen again. He was reminded about the fact that he could access support through Student Support Services, but he declined this offer and said he did not need it.

2.3.8.4 During the course of the police enquiries into the deaths, a fellow student of Grant reported that she had been sexually assaulted by Grant on an evening during March 2017. He had arrived at her home drunk and unannounced. She agreed to drive him to another address. At some point during the journey, whilst she was driving, he grabbed her breasts over her clothing and said, 'I know you fancy me. You need a real man to sort you out'.

2.3.8.5 Also in March, a female course manager met Grant as she was walking across the campus, he tried to cuddle her and said, 'mate – long-time no see – you are looking lovely'. The tutor backed away and said, 'inappropriate Grant' and thanked him for the compliment. She did not take any further action as she just took it as banter.

2.3.9 **The final three weeks**

2.3.9.1 The family received notification of repossession proceedings and the date of the court hearing three weeks before their deaths. A letter was also received by The District Council with this information and a standard advice letter and information booklets were sent out by them to the couple.

2.3.9.2 On the same day, Grant attended the College of West Anglia. The lecturer was unwell and had to end the session early. As she came out of the toilets, Grant was waiting for another student who came out of the toilet and she had clearly had been crying. She and Grant left together. When the lecturer mentioned this to the tutor the next week he confirmed he was not aware of any problems but did know that there were rumours that they were in a relationship.

2.3.9.3 On a Friday, towards the end of March, Grant attended the College of West Anglia and was heckling the guest speaker. When the students later complained about this they said he

appeared to be under the influence of alcohol. This was also the last day that Louise was at work.

2.3.9.4 At 4.30pm that same day, Louise spoke to the church warden about borrowing money and was advised to speak to the vicar. Louise left a phone message for the vicar. (This was his day off and he got her message at 11pm.)

2.3.9.5 Louise returned home and heard Grant on the phone to a lady who it is believed Grant was having a relationship with. When one of the couple's children returned home at about 8pm he found them having an argument about the telephone call. The child has told this Review that Louise was more upset than he had ever seen her before and she told him that she had 'caught him red-handed'. When the son asked what she meant she said she had heard Grant on the phone saying, 'my dick would fit in your hand perfectly'.[8] Grant was drunk and denied this, but his son told him he believed Louise. The son then went out and did not return until 1am on Saturday morning. When he arrived home, she was asleep on the sofa with a duvet, as she had been for a number of days. He had a brief conversation in which she told him she no longer wanted to be with Grant. She said that, due to money worries, she would have to file for bankruptcy and move to a smaller house.

2.3.9.6 The following day (the Saturday morning), the vicar left a number of messages for Louise but, when he had not heard from her, as he had sensed urgency in her voice, he phoned the landline and spoke to Grant. The vicar described Grant as being very chatty. At 3pm Louise rang him back and they arranged for her to go straight round and she arrived 20 minutes later. When she arrived, he found her to be very different from other times when he had seen her – she was crying a lot and he noticed that she was looking very thin.

2.3.9.7 Whilst there she told him that Grant had, had an affair but they were going to put it behind them and move forward together. She described to him that they were in terrible financial difficulties and that Grant did not realise or accept the full extent of the trouble they were in. She wanted to make decisions but did not seem to know how to do this. He spent at least an hour with her and they talked about practical matters. By the end of the conversation, he felt that she had come to some decisions and had a more positive disposition. He described Louise as being a lady who could cope with almost any situation, as long as she had a plan of action.

2.3.9.8 Louise's plan was for the whole family to downsize. The vicar rang a local councillor and she spoke to him on the phone. The councillor suggested a number of options and told her to contact the council's emergency number if she was going to make herself homeless. He said that if she rang them she could use his name. Once the phone call was finished, they discussed what she could afford to pay for rent. The vicar told her that if they rented a house in a particular town then the church could pay the deposit.

2.3.9.9 The vicar described her disposition as having changed completely from when she had arrived. She now had a plan and felt more positive. Louise left to go home and talk to Grant about the plan.

[8] The person to whom this call was made has confirmed it to be true

2.3.9.10 Their younger son came in at 1.30am on that Sunday morning and Louise was asleep on the sofa. She said 'hello' to him. This was the last time he saw her alive. That Sunday was Mother's Day. He went to bed, although he did not look in on his dad he could hear him breathing. When he got up at 11am that Sunday morning he noticed that all of the cars were on the drive. Grant was in the living room and appeared to be drunk but he could not find his mother and Grant told him that her friend had come to collect her and take her out for the day. He thought this was strange as it was Mother's Day and he had a card and flowers that he wanted to give to her.

2.3.9.11 Louise's eldest son also sent her a text to wish her a happy Mother's Day.

2.3.9.12 At 5.15pm her younger son sent a text to Louise asking where she was, and he received a reply from her phone at 7.25pm saying she was out with a friend and would be home late.

2.3.9.13 The following morning (Monday), Louise's eldest son received a text from her phone at 6.30am.

2.3.9.14 At 7.30am a colleague was setting up at school and thought that it was odd that Louise was not there, as she usually would have been. About this time, Grant phoned the school to say that she would not be in as she was unwell with a temperature. He was reminded about the protocol that Louise should ring personally.

2.3.9.15 Their younger son got up and found his dad drunk and asked if his mum had come back. He told him she had come home early to collect some things and had gone out again. Although he thought this was unlike his mother he was not overly concerned. He noticed that the card had been opened and the flowers had been put in a vase.

2.3.9.16 On the same day, a tutor at the College of West Anglia at which Grant was a student, met with two students on his course who were concerned about his behaviour saying that his behaviour was starting to disrupt the class. The students were also concerned about him drinking and driving. They said they no longer wanted to work with him in a small project group. The tutor was played a recording of him heckling the speaker and agreed that this seemed to support the assumption that he had been drinking. At this point the tutor made a decision to suspend Grant on the grounds of his behaviour during the lecture and being under the influence of alcohol at college. She emailed him to advise him of this and to invite him to attend a disciplinary hearing on 31st March. Grant did not respond to this email and never attended college again.

2.3.9.17 Grant called the school again the next day to say that Louise would not be in. He was again asked to ensure that Louise made contact with the head teacher as per the protocol. Grant contacted the head teacher reporting that she was too ill to attend school. He was reminded by her that Louise must make contact herself, but he said that she is too unwell to get out of bed. Later that day a text was received by the head teacher from Louise's mobile saying she would not be in for a few days as she was unwell. An attempt was made to phone her mobile, but it was not answered. The head teacher did not believe that this message came from Louise herself as her name was spelt incorrectly, the punctuation was poor by Louise's standards and she did not end the message with 'xxx' which she always added. The school made further attempts to contact Louise by both text and telephone over the next few days and received either a reply from Grant or no reply at all. The school

escalated her non-contact to the school governors and the chair attended her home the next weekend to try and speak to her. There was no-one at home, so he attempted contact through friends that he knew of the couple. He was eventually told by friends, via Grant, that she had flu.

2.3.9.18 Louise's younger son had not contacted her since Mother's Day as he thought she wanted some space but on Thursday (or Friday) he rang her mobile and heard it ringing in the same room, eventually he found it between a cushion and the arm of the sofa. Again, although he thought this was odd, he did not think too much about it and left the phone on the table.

2.3.9.19 Whenever he saw his dad between Mother's Day and the day of his death in early April he was 'off his head on alcohol', he had changed from an aggressive drunk to a depressive drunk, had stopped showering and was hardly talking.

2.3.9.20 On Thursday the younger son checked his bank account and saw that £150 had been withdrawn. He immediately knew his dad had taken it and he confronted him. He found £80 in his trouser pocket and that the rest had been spent on alcohol. He then left the address and started to stay with friends, only returning home to feed the dog. He was contacted by his aunt to tell him his dad had gone to Halifax for a few days. Over the next few days, he had friends to stay at the house.

2.3.9.21 The head teacher sent a text to Louise's phone, although school had now broken up (for Easter) asking her to call when she was able to discuss some changes that had taken place in the school during the last week.

2.3.9.22 On the Sunday of that weekend, Grant's uncle reported to West Yorkshire Police that he was causing problems for him in Halifax. He was driving a car on the road whilst drunk. He was then seen by officers and requested to stop when he gave a positive breath test at the roadside. He was arrested on suspicion of driving whilst over the limit.

2.3.9.23 Whilst in custody a risk assessment was completed, and it was identified that he had diabetes, had consumed a bottle of vodka and was feeling low which is why he had been drinking so much. A further risk assessment was completed an hour or so later, and it was noted that officers had found a rope in the back of his car. When he was asked about it, he said he had been doing some DIY. A healthcare professional was requested to see him due to his intoxication and blood sugar levels. A care plan was completed, and he was noted as medium risk in relation to his health and wellbeing due to his diabetes and being intoxicated. He was medium risk in relation to his safety to himself due to the rope found in his car. He was placed on 30-minute 'rouse and respond' visits. He was also examined by a healthcare professional and he had denied any thoughts of self-harm or suicidal ideation.

2.3.9.24 Grant was charged with driving a motor vehicle over the prescribed limit and no insurance. He was provided with a keeping safe leaflet and the phone number for the mental health team. He was then released from custody at just after 1pm on unconditional bail to appear at court later in April, having been allowed a telephone call to book a taxi.

2.3.9.25 He was arrested again only an hour or so later after his uncle reported that he had returned to the area and was again causing problems. He said he believed that Grant was under the influence of drink and had been driving again. He provided a breath test and was arrested on suspicion of being drunk in charge of a vehicle.

2.3.9.26 After his arrest, a care plan was completed in which it was documented that his family were concerned about his suicidal intentions, but he had been seen by a healthcare professional and had denied this. No current intent was stated, and he was placed on 30-minute 'rouse and respond' visits.

2.3.9.27 As he had now been arrested twice in two days for a similar offence, the crisis team in Lincoln were spoken to and they confirmed that he was known to them but had no current contact and had last seen him in 2012. The family had attended the police station and were concerned about his mental health. When he was remanded for court, the sergeant was aware to highlight to the court the family's concern over his mental health and that he could see the court Crisis team if needed. The police also spoke to Grant's older son who expressed concern about his mental health which included possible depression and potential for self-harm. He said he would travel from his home in London to support him in the coming days.

2.3.9.28 When he was interviewed, Grant admitted that he had, had a drink but denied driving the car. He was charged with being drunk in charge of a motor vehicle and was remanded in custody at the police station to appear at Bradford Magistrates Court later that day.

2.3.9.29 Whilst in custody he was seen for a mental health assessment. There was no evidence of any severe or enduring mental health problems and he had no thoughts to harm himself. It was stated that a letter would be sent to his GP and the nurse would liaise with mental health services in Lincolnshire. During this assessment he disclosed that he had come to the area to visit his aunt who had recently been discharged from hospital and, following a family argument, he had bought a bottle of vodka (this was when he was arrested the previous day).

2.3.9.30 The case was reviewed and it was felt that the evidence was not sufficient for a realistic prospect of prosecution in court and that he should now be released. He was taken to his uncle's address to wait for his sons to arrive.

2.3.9.31 At some point that day, the elder son returned home to Lincolnshire from university. The only thing that caused him concern when he arrived was that Louise's glasses were near the TV. As this was the only pair she had, he thought it was odd that she had not taken them with her.

2.3.9.32 Grant returned home from Halifax the following day (the Thursday)

2.3.10 **The day of Grant's death.**

2.3.10.1 The following morning (Friday), the couple's youngest son contacted the head teacher of the school where his mum worked (although it was the school holidays) to see if they knew where his mum was staying. She had explained that they had not been able to speak to her.

2.3.10.2 As the youngest son left the house to go to work, he did not see his dad, but he noticed that his car was on the drive, so he assumed that he was walking the dog. He walked to the bus stop and then received a call from his brother to say that his dad had hung himself.

2.3.10.3 The eldest son had woken late and found his father hanging in an outbuilding. He then took his dad's car and drove to a neighbour's house to look for help. The neighbour's daughter was there, and they drove back together. She found Louise's phone under the driver's seat. The son used this phone to contact the friend where he believed Louise had been staying and she said this was not the case. He also contacted his mum's work colleague who told him that his dad had been reporting her as too ill to come to work.

2.3.10.4 It was just after 1.30pm the police received the report that Grant had been found hanging. When they arrived, he had already died.

2.3.10.5 When the police arrived, concern was raised for Louise who it now emerged had last been seen alive in the early hours two previous Sunday's ago. She was classified as a high risk missing person and the property was contained.

2.3.10.6 The police engaged a specialist search team to begin a systematic search of the property and two days later Louise's body was discovered in a rarely used ground floor room described as a storage room. Her body had been concealed under wallpaper, some black cloths and a pile of laminate flooring. Louise was formally identified via DNA.

2.3.10.7 Following post mortem and toxicology, the cause of Louise's death was and remains unascertained. There was no evidence that she died from natural causes and the toxicology results did not indicate that she had taken anything that would have caused her death.

2.3.10.8 Grant's death was determined as a result of hanging with no third-party involvement.

Section Three – Analysis

3.1 Cultural issues

3.1.1 In order to understand the cultural issues that may have affected the views, attitudes and decisions of both Louise and Grant the report author has spent time with someone who was able to support our understanding. This person spent five years studying cross-cultural issues before living and working in Pakistan for five years as a Christian missionary working with the Pakistani Christian population.

3.1.2 Whilst we know that both Grant and Louise were from Christian heritage in Pakistan which makes up a small minority (approximately 2%) of the population, it has been important to the review to understand that culture and religion, for them both, will have been very interlinked, and they would have been influenced very much by the culture of their home country, whilst practising as Christians.

3.1.3 In their Eastern culture, their experience of family life may have been very different from that which many of us in the western culture would recognise. This was seen when Grant and Louise met with the social worker. Grant clearly stated that in his culture a man is in charge and this is how he was brought up. He did not believe that he needed the help of children's services and whilst Louise did not agree, for them, the needs of their family would have been much greater than their own needs and maintaining the family unit would have been paramount.

3.1.4 There are important aspects of how the roles of men and women are defined within this culture. Women are seen as guardians of the family honour and there may have been expectations of obedience from her.[9] Research and the lived experience of our advisor, indicate that boys are not equally affected by these demands[10] which might suggest why Grant's behaviour was tolerated by the wider family.

3.1.5 It is important that we do not overlook the place that shame would have been likely to play in both of their lives. For Louise, we see evidence of her keeping the problems secret and this may well have been, at least in part, a desire not to bring shame on her family, particularly given the position her father held as an archbishop in Pakistan. Her 'shaming' of the family might also have sparked further violence.[11] Grant also may have been very influenced by shame and we know that he was not happy when he knew that she had asked the church for help and this may have led to him feeling shamed. In their culture, they would have expected help to come from the family but, for Louise, the church was her family too.

3.1.6 If we consider why Louise did not disclose the full extent of the violence we might do well to remember that whilst she made some disclosures; within her culture disclosures could increase the risk of violence, possibly even leading to long term rejection from the group

[9] Bano S, 2012, Muslim Women and Sari'ah Councils: Transcending the boundaries of Community and Law, Basingstoke, Palgrave Macmillan

[10] Dion K K and Dion K L, 2001, Gender and Cultural Adaptation in Immigrant Families, Journal of Social Issues, 57 (3), 511-521

[11] Bano S, 2012, Muslim Women and Sari'ah Councils: Transcending the boundaries of Community and Law, Basingstoke, Palgrave Macmillan

(or family) due to the rigid rules of family honour.[12] In her eyes, the greater good may not be removing the risk of violence at all costs but maintaining her place in the family whilst minimising the risks to her and the boys. South Asian culture is collectivist, prioritising group welfare over individual freedoms and we can see how this may have influenced her decisions about seeking help.

3.1.7 The role of Christian faith for Louise, in particular, cannot be overstated. We know that it played a pivotal place in her life. We know that she would turn to God and pray, on her own and with others, at the times when life was most difficult for her. It is, therefore, important that we consider the influence that this would have had on Louise and the decisions that she made.

3.2 Louise

3.2.1 In understanding the dynamics of this relationship between Louise and her husband it is important to try to get to know them. This has been done, in Louise's case, by talking to those who knew her well – her sons, her close friends and colleagues and her vicar.

3.2.2 The Louise that we have been introduced to is a capable and hard-working woman who wanted the very best for her family. Her Christian faith was very important to her and friends talked about her turning to God for 'answers and solace'. She was, we believe, also greatly influenced by her Pakistani culture and heritage. One person described her as 'an incredibly strong person, an incredible woman; a ray of sunshine in our lives'. She was always smiling and full of life but, it has been suggested, this belied what was really going on. She was also described as a very private person by almost everyone whom the review spoke to. We can see that she was extremely hard-working; she worked full-time and studied for her degree whilst bringing up her sons and looking after the home and Grant, with his associated issues.

3.2.3 Louise was portrayed by anyone we spoke to as a strong woman. A number of people talked about how she would handle him when he was inappropriate or had been drinking. She would, we were told, say to him 'enough now'. We know that Louise was embarrassed by Grant's drinking and we could speculate that she gave up her role as Church Warden because she felt that it was not right for her to continue. What we do know is that she was trying to do what was best for Grant to help him with his drinking and depression.

3.2.4 Everyone that contributed to the review, talked about Louise changing from December 2016. A number of people commented that she had started to lose weight and became distracted and preoccupied, she would forget things easily. She became distant and her performance at school dipped.

3.2.5 She was described as someone who liked to have a solution. However difficult things were, if she had a plan she would get on with it. She met with her vicar on the day before we believe she died, and he described her as being very tearful and not her usual self. She described needing to make decisions, but she was not sure how to do this. After spending some time talking she came up with a plan which she went home to discuss with Grant and

[12] Lago 6, 2008, Race, Culture and Counselling: The Ongoing Challenge (2nd edition), Milton Keynes, OUP

her disposition on leaving was very different. She now had a plan and she felt more positive.

3.3 Grant

3.3.1 Grant was described as someone who could be good fun and good company but when he had been drinking he was very different. He was a very talented man and had done a lot of work on the house. He could be humorous and mischievous, changing his accent depending on who he was speaking to. He was a man who knew how to 'play the game'. He clearly had part of his character that rebelled against rules. His disregard for his disqualifications from driving is clear evidence of this. He was caught, prosecuted and banned from driving on several occasions but kept doing it.

3.3.2 Louise's friends and colleagues who had met Grant described him as 'very loud and in your face' and he always made sure he had a flashy car. For Grant, cars seem to have been a status symbol that was very important to him. His sons talked about his love of cars. One colleague of Louise described having once got in the car with him. This colleague had vowed not to do it again because he was 'a crazy show-off driver'. Grant liked a lavish lifestyle and the trappings that went with this. He was described both as a very generous man who could appear as a 'flash harry'. Even when he was not drunk, he was very loud and liked to be the centre of attention.

3.3.3 Grant was described by one lady as someone who always would make comments to women. He was a joker, full of stories and a flirtatious entertainer. A couple of friends described Louise as being the butt of all his jokes and whilst, in the main she went along with it, there was a cutting edge to his comments and the friends felt uncomfortable.

3.3.4 We know, from those on his college course, that he was prone to bragging about work he had done in the past and what he was going to do in the future. There were incidents where he was disrespectful to tutors and guest speakers at the college, questioning what was being said to him. Grant was a man who did not like to be told what to do.

3.3.5 Grant had, for the most part, been out of work in the time that the family had lived in Lincolnshire. He had, purportedly, been constantly seeking work and to be back in work was very important to him. However, for more than 18 months he was telling his doctor that he was unfit to work until September 2016 when the GP was advised by DWP that he was now fit for work. At this point, Grant enrolled on a four-year degree course. One might wonder why, if he was so keen to be back in work, he would make this commitment.

3.3.6 When Grant was drinking his behaviour could become inappropriate. A number of people told us about an incident when the teachers from Louise's school went on a night out and Grant joined them. She had told one or two people beforehand that she was going to let him have a drink, but she said afterwards she had regretted this. Grant had been drinking and he was very argumentative in the queue to the nightclub. They had only been in the club a short time when something else happened and Louise had taken him home. She apologised to her friends the next day for leaving so abruptly, saying she knew that there was going to be trouble. On another occasion, he arrived at a church function and had been drinking; Louise was very embarrassed and took him home.

3.3.7 Grant was a man who suffered greatly from alcohol abuse. Alcohol is a depressant and at times the alcohol abuse caused depressive behaviour and, occasionally he had suicidal thoughts. There were at least two occasions when the way he spoke to someone on the phone some few hundred miles away concerned them sufficiently to phone the police, concerned for his welfare.

3.3.8 There are incidents that suggest that Grant did not hold his marriage in the same regard as Louise. For example, the review has been made aware of an affair in which he was engaged. Since his death, there have been reports made of inappropriate sexual behaviour and, although a good number of years ago, he was spoken to by the police about being in a red-light area.

3.4 Evidence of domestic abuse

3.4.1 Domestic abuse takes many forms and what we see in Grant is a man who was controlling and manipulative in many situations. We have no doubt that this was true of his behaviour towards Louise, but as she went to great lengths to keep this from even her closest friends, we cannot know the extent to which this went on.

3.4.2 We have one example, at the end of 2013 and the beginning of 2014, where this was witnessed by the social worker following the incident when Grant pushed Louise and the police were called. When the social worker arrived at the house, Grant began by asking if she wished his son to sit away from him so that he could not influence him. He argued with the social worker (and Louise) about why the assessment was being done, saying it was a waste of time. He minimised his behaviour by saying every family has its 'ups and downs'. On a couple of occasions, he asked his son if he had any problems but did not give him chance to answer. When he did try to answer, Grant was talking over him and did not acknowledge him. Grant refused to give permission for his son to be spoken to alone at school but did agree they could speak in the next room. His son said that he did not like to talk to his teachers but if he needed to, he would speak to his mum. As the social worker left, Louise tried to close the door (presumably to speak in private) but Grant prevented this from happening and followed them to the door. The social worker recorded that she had concerns, not necessarily about physical altercations, but in terms of the controlling behaviour within the home and the way that he presented as aggressive and controlling.

3.4.3 We know that when Grant was arrested following the incident at the end of December 2013, which led to the social services involvement described in the previous paragraph, he said when he arrived in custody, 'she is going to fucking regret this'.

3.4.4 There have been examples of behaviour which friends have described as being unusual or odd which the review would interpret as controlling. For example, towards the end of December 2016, Grant took to ringing the school numerous times each day. He would be told that she was busy teaching and would stress that it was urgent so that she was brought to the phone. We are not able to know the content of these calls as Louise always spoke in her native tongue. When Louise went to see Women's Aid this was on a day when Grant was in court, so she knew that she had time to go and do this uninterrupted. Whenever Louise's colleagues from work would go out socialising Grant would go too. There was also an occasion when he even went to a baby shower which was considered inappropriate. Her friends described her as being 'quieter' when he was around.

3.4.5 Although we cannot know the full extent of his control and manipulation of Louise, what we can see are examples of his controlling and manipulative personality in other situations and relationships.

3.4.6 Grant's friends described him as being manipulative, 'he was always two steps ahead of you'. He manipulated friendships and the image of himself that he liked to portray. He was known for being 'flash' in the pub and making a big show of buying drinks for everyone. He, on one occasion, put a £20 note in the church collection so that everyone could see. This might, as was suggested by the person who told us about it, have been an example of his generosity or, alternatively, it might have been another example of him manipulating people's impressions of him.

3.4.7 Grant was obviously able to tell a good story and was very plausible. He was able, on more than one occasion, to persuade car dealerships to lend him top of the range cars to try out 'as he might be thinking of moving his company's fleet to them'.

3.4.8 We see, in Grant, a man who would always seek to ensure that things happened on his terms. He was referred by LPFT for a stress management course but only attended two of the five sessions. When he attended BetelUK and AA, he stayed for as long as he wanted and took from the intervention what he wanted. When he was before the courts, on one occasion he was required to undertake unpaid work which he clearly did not want to do, after turning up drunk one day this was deemed unsuitable and, when taken back to court it was replaced with a curfew. On another occasion, he obtained sick notes from his doctor so that he did not have to engage in a work party.

3.4.9 We cannot know the extent to which Louise was a victim of financial abuse but what we do know is that for many years she shouldered the burden of their finances, seemingly alone. Their finances were a constant worry for Louise, although she kept this from her sons. She was the sole earner in the family, working full time whilst looking after the family. They lived in a large house and were, on and off for many years, in danger of the house being repossessed. She had on numerous occasions asked friends, colleagues and even her employer to lend her money or give her food. In July 2014, she accepted a formal caution for benefit fraud having not provided the correct information to support a claim. We will never know the part that Grant did or did not play in this. What we do know from interactions with services is that Grant did nothing to try and alleviate their position and it was left to Louise on every occasion except one, to contact the council or other people to sort out their financial situation. The only occasion when Grant did seek help was when he had been removed from the home by the police, having been violent to Louise and he was hoping they would provide temporary accommodation.

3.4.10 We also know that Louise saw a solution to their problems would be to declare themselves bankrupt, sell their house, rent a smaller house and start again. Despite all that they had been through, she wanted this new start to be for them all. She had talked with her vicar, before returning home prior to her death, about this plan and had arranged with him for the church to give them the money for the deposit on a rented property. We know, from previous times when this had been considered, that Grant would not agree, seeing the shame of losing his big house and declaring himself bankrupt as worse than their current situation.

3.5 Operation Encompass[13]

3.5.1 As part of this review, it has been very clear that the sons' schools appeared to have no knowledge of the incidents that were taking place at home. This obviously means that any opportunity to support the children was missed. The review has been made aware of Operation Encompass; a police and education early intervention safeguarding partnership being run in some parts of the country. The scheme reports to schools before the start of the next school day when a child or young person has been involved or exposed to a domestic abuse incident the previous evening. The information is passed in strict confidence to the school's Key Adult to enable support to be given dependent on the needs and wishes of the child. This scheme is recommended as good practice for all forces by HMICFRS.

Recommendation

(1) The review is aware that Lincolnshire is currently working on an ICT solution to enable frontline officers at domestic abuse incidents to accurately capture the information relating to children and their schools. This school information has not been historically captured in Lincolnshire. It is recommended that the business case for implementation is seriously considered and that the scheme is adopted as soon as possible.

3.6 Influence of alcohol

3.6.1 It is important that we acknowledge that whilst Grant and Louise had a complex relationship, by the nature of this review, we have focused upon the times when it was at its worst; the boys will talk about some very happy times as a family which could extend to months at a time except when their dad was drinking. It appears that, at least until the more recent years, Grant could go for some weeks or months without drinking and then he would begin to drink socially, and it would spiral out of control. Christmas was described as one such trigger.

3.6.2 However, over the years Grant's drinking became more and more of an issue causing him to lose a number of jobs. Friends and family described Grant as being desperate to give up drinking but his interactions with treatment services does not support this view. For example, he was inconsistent in the information that he gave and did not engage fully with the treatment and support offered. He would on occasions, minimise the amount he was drinking; telling LPFT he had given up drinking when three days earlier, he had told Addaction he was drinking a litre of vodka each day. He did not sustain his involvement in treatment services, not really engaging with Addaction. He entered BetelUK which was seen, at least by Louise, as going to be the help he really needed. The programme was 12-18 months, which would have been explained to him when he entered but he left after only four weeks, saying he had got what he wanted from the programme. We understand that he would have, in this time, been through detoxification but left before he could begin therapeutic work to confront the underlying causes of his drinking and develop strategies to stay away from alcohol. On another occasion, he said he had been to AA and, whilst he did not like the 12-step programme there were things he did like so he would continue to

[13] http://www.operationencompass.org/

go. We know that, on more than one occasion, he entered some form of rehabilitation and left, begging Louise to let him come home.

3.6.3 We are left with a view of a man who was not really committed to addressing his alcohol issues. We will never know why this was the case, but it was said to us, in relation to rehabilitation, that he would not have liked to have been told what to do. This view of Grant as a man who did not like to comply, is supported by the evidence, over many years, of him not complying with his diabetic regime even though he would know that he was putting his health at risk.

3.6.4 As so many people we spoke to about Grant attributed the problems in his marriage and life to his problems with alcohol, it is important that we face head on the role that alcohol may or may not play in domestic abuse.

3.6.5 Research finds that between 25% and 50% of those who perpetrate domestic abuse have been drinking at the time of the assault[14] and cases involving severe violence are twice as likely to include alcohol[15]. It has also been found that in an intimate relationship where one partner has a problem with alcohol or other drugs, domestic abuse is more likely to occur[16]. However, the impact of alcohol on domestic abuse is complicated.

3.6.6 It is important that we remember that domestic abuse is about power and control by one partner over the other. Not all alcoholics are abusive and not everyone who abuses their partner is alcoholic. Whilst we can say that alcohol is a compounding factor in a person being abusive towards their partner, we must avoid suggesting that it *causes* it. Alcohol is *not* the cause of the abuse or the violence, the desire for power and control is. Alcohol may be offered as a reason, or an excuse, by a perpetrator for the abuse. This is not, and should not, be accepted and the responsibility for actions remains with a perpetrator.

3.6.7 Alcohol was a factor in this case, but Grant's character is at the root of the issues within this relationship, alcohol compounded them.

3.7 Why did Louise tell some of her story but not all of it?

3.7.1 This review was told, by a number of people, that Louise loved Grant very much. We know that, over the years, there were times when one or the other of them would move out of the house, but they always reunited. Louise was a private woman who wanted to protect Grant.

3.7.2 We have had lots of evidence from friends and colleagues that Louise shared some very personal information with them, but she did not tell them everything. She would tell them about the depression he was experiencing but not his problem with alcohol, about the

[14] Bennett L and Bland P, Substance Abuse and Intimate Partner Violence, National online recourse centre on violence against women, cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

[15] McKinney C et al (2008), Alcohol Availability and Intimate Partner Violence Among US Couples, cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

[16] Galvani S, (May 2010), Supporting families affected by substance misuse and domestic violence, The Tilda Goldberg Centre for Social Work and Social Care, University of Bedfordshire, ADFAM, p5 cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

money worries but not the violence. Only Louise knew why this was the case, but we do know that she told the police that she could not talk to her family or friends or he would call them and ask them not to be her friend. The fear that this instilled in her demonstrates the importance that they were to her and the control that he had over her in that she believed he would do it.

3.7.3 There is no doubt that her cultural and religious background would have played an enormous part in her thinking and her actions. She had married Grant, against the advice of her family, in the eyes of God and she had married for life. We have heard the strength of her faith in every area of her life and she was known, on more than one occasion, to ask friends to pray for her and her family. She believed that God could answer prayers and the situation could change. It is important that we recognise that whilst this is a view that she may have held fervently, if she had made a clear disclosure about the level of domestic abuse she had been experiencing, her priest and others in the church would have encouraged her to keep herself and the children safe even if this meant leaving her marriage. Current Church of England teaching clearly states that 'The pattern of living that is revealed through Jesus in his relationships with others entails that abuse of any kind is contrary to the will of God and an affront to human dignity. This entails a heavy responsibility upon the Church and its members to do everything possible to prevent or halt it.[17] Within the current safeguarding guidelines provided for Clergy and laity in responding to disclosures of domestic abuse the point is made that those receiving disclosure should ensure their response emphasises that the marriage covenant is broken by the violence from their partner.

3.7.4 Forgiveness is a Christian virtue because it lies at the heart of how God is with us. Love and forgiveness are offered by God without question, but they are not without cost and they require a response of repentance in every human heart.[18] 'Repentance is much more than being sorry. It is about taking a new direction, following a new path, with whatever that might entail. We cannot repent and carry on just as we did.'

3.7.5 At a fundamental level, Louise may have felt that she must forgive Grant for his behaviour towards her. Jesus talked about forgiving those who have wronged us[19] and it is very possible that Louise felt that she must continually forgive Grant – time and time again. It is possible, although we cannot be sure, that Grant would use this in his manipulation of Louise.

3.7.6 It is important that we remember that, whilst the church would encourage forgiveness on the part of all the followers of Jesus, the pattern of living that is revealed through Jesus in his relationships with others means that abuse of any kind is emphatically contrary to the will of God and an affront to human dignity[20].

3.7.7 Whilst Louise might have believed that she must continue to forgive Grant no matter what and stand firm to her marriage vows this is not a view that the church would have encouraged.

[17] House of Bishop's Practice Guidance 'Responding well to Domestic Abuse'. Church House Publishing March 2017 section 1.2 pg 8
[18] The Venerable Gavin Kirk, Archdeacon of Lincoln – Forgiveness reflection for abuse survivors, 2017
[19] Matthew 18:21-35
[20] Joint training between YHLCOSA and the Diocese of Lincoln Safeguarding Team

3.7.8 Louise also would not, as we discussed earlier, wish to bring shame on her family or on Grant by speaking about his problems. It may be difficult for those from a western culture to understand why this was so difficult for her.

3.7.9 Whilst this review has referred to her religious and cultural beliefs, we acknowledge that there may have been other reasons why Louise did not tell anyone about her situation. Although we see, in the picture that has been painted for us of Louise, a cheerful and competent woman there is no doubt that she was controlled by Grant and, most probably, afraid of him and what he was capable of.

3.7.10 The review panel has spent some time considering the position that Louise was in as a professional woman who would be dealing with safeguarding issues on a day to day basis. She knew that if she disclosed the violence and abuse that she was experiencing there would be consequences. Agencies would have become more involved and this could have had a life changing impact upon her, her children and her career. This may lead women in such a position to minimise to themselves and others the abuse that they are experiencing and not to seek help. She was, in her work, supporting children who had been affected by domestic abuse and therefore she would know the impact that this could be having on her own children. This has raised questions for the panel about how organisations with safeguarding responsibilities encourage staff who are suffering from abuse to seek help from their employers.

Recommendation

(2) It is recommended that the Safer Lincolnshire Partnership considers actively encouraging organisations to engage with the available work-based employee initiatives with a view to improving the support to employees who are victims of domestic abuse.

3.8 Detailed analysis of agency involvement

The chronology set out in Section 2 details how the information known to agencies evolved. This section summarises the totality of the information known to agencies and others with influence during the years leading up to the deaths. The detailed chronology will not be repeated here; rather this section will provide an analysis of agency involvement.

3.8.1 Lincolnshire Police

3.8.1.1 Louise had no criminal convictions but did have two driving convictions[21].

3.8.1.2 Grant was recorded on PNC with warning signs for being a diabetic and being suicidal.

3.8.1.3 He had one police caution for an assault on his wife committed on 16th April 2011 and had six previous convictions relating to nine offences:

- 1 x assault on his wife committed on 13th December 2013
- 1 x failing to comply with a suspended sentence supervision order
- 7 x various driving offences including driving whilst disqualified, several drink-driving offences, failing to stop after a road traffic accident and having no insurance

[21] The details of these incidents/offences are included in the full chronology

3.8.1.4 There were six incidents of domestic abuse reported to the police over a period between April 2011 and December 2013. The DASH risk assessment for the incidents in 2011 and 2012 were graded as 'standard' and all three incidents in 2013 were graded as 'medium' therefore no referrals to MARAC were made. It is clear that the police officers responded appropriately in each of these cases, with positive action being taken and the DASH risk assessment being completed.

There have been changes in practice since these reports which will be explored in more detail later in the report, but the review is satisfied that Lincolnshire Police took positive action on each occasion that they were called in line with the interventions available to them at that time.

3.8.2. Queen Elizabeth Hospital NHS Foundation Trust, King's Lynn

3.8.2.1 There is no indication that Louise presented in either department with indicators of possible domestic violence or abuse.

3.8.2.2 It is recognised by the hospital trust, in its IMR, that attendance at these services would provide an opportune time, when females are seen alone, to ask a routine question about domestic abuse. It was also acknowledged that whilst posters and leaflets were available in the Gynaecology Clinic, this was not the case in the Breast Care Unit.

3.8.2.3 The Queen Elizabeth Hospital has identified named domestic violence and safeguarding champions in the Trust. The safeguarding champions' network was re-launched in September 2017. Currently there are no champions identified from either the Gynaecology Outpatient Clinic or the Breast Care Service.

Recommendation

(3) That the Gynaecology Outpatient Clinic and Breast Care Service at Queen Elizabeth Hospital each identify a practitioner to complete the domestic violence champions training (delivered locally by Norfolk County Community Safety Partnership) and to attend the safeguarding champions' group.

3.8.2.4 There was no evidence of a routine enquiry of domestic violence being undertaken or that the QEH policy is being followed. The policy states that 'all trust staff must be alert to a patient's possible domestic abuse, or one that is displaying indicators of domestic abuse, and be confident in making a sensitive enquiry in private to ascertain the details and then report the situation'. The NICE public health guidance 50, February 2014: Domestic violence and abuse: how health services, social care and the organisations that they work with can respond effectively, states that all frontline staff should be trained to recognise indicators of abuse and ask relevant questions to help people to disclose.

Recommendation

(4) That Queen Elizabeth Hospital audits whether staff are routinely asking the question of domestic violence and abuse[22]

(5) That QEH Trust Domestic Abuse Policy is updated to include NICE guidance recommendations

(6) That the safeguarding children and adult team at QEH review the current provision of training around domestic violence and abuse against the NICE Quality Standards 2014

3.8.3 School Employer

3.8.3.1 The IMR found that the absence management procedures were fully followed but, in response to this incident, staff are now much quicker to respond to do safe and well checks when staff have not been spoken to directly. The local PCSO has also given her commitment to supporting with this. It should be noted that the school are so committed to improving this area that they are continuing with safe and well checks. This is despite a complaint of stalking from another member of staff.

3.8.3.2 The awareness raised by this case, has led to a safety plan being put in place by the pastoral teaching assistant where they have concerns of domestic violence for another member of staff.

3.8.3.3 When considering the IMR from the school employer, the panel discussed the Absence Policy of Lincolnshire County Council and it was noted that the school had complied fully with the policy. However, the policy does not provide any guidance on the action that should be taken if a person does not comply with the policy and contact the employer themselves. There was concern about the intrusive nature of a safe and well check on an employee absent with, for example, work related stress. A recommendation is made to address this issue.

3.8.3.4 The school employer, when hearing of the full details, were able to identify that at two significant points, Louise had not attended work due to illness. The school is, consequently, strengthening their 'return to work' meetings to include any issues or concerns outside of school.

Recommendation

(7) That Lincolnshire County Council reviews its absence policy with a view to providing more guidance on the action that should be taken when a member of staff does not comply with the policy and make contact personally. This review should consider how the school and unions and can work together to ensure that staff understand the need for a safe and well check

3.8.4 Lincolnshire County Council – Children's Services

3.8.4.1 Children's Services had contact with the family on four separate occasions, either directly or through a referral from another agency. The main contact was when an assessment was carried out on 18th December 2013. The IMR identifies that the assessment was to a good standard and a verbal safety plan was agreed with Louise for the Christmas period. When Grant returned to the home in January 2014 it is noted that he was not enthusiastic about

[22] As per NICE guideline PH50 2014 and Nice Quality Standards 2016

children's services involvement and unable to understand the explanation given around the impact of domestic abuse on his children. He was of the view that he had never hurt his children and never would do. Louise, however, appeared to have no problem with their intervention. Grant would not agree to his younger son being seen alone at school or to signing a written agreement[23]. Given the circumstances, the risks to his son were not assessed as requiring escalation into child protection and therefore, as child in need work requires the parents' consent, the case was closed and the child in need plan was not activated. On balance, this seems a fair decision. The social worker's notes of this last meeting have been provided to the review and will be referenced in the analysis later in the report.

3.8.4.2 Children's services identified, in its IMR, that it would have been preferable to try to see the child alone before the case was closed as would the completion of a DASH risk assessment by the social worker as well as the police. This is now standard practice.

The review acknowledges that the work was undertaken in line with practice at the time and that procedures have now been changed to ensure the risk to victims of domestic abuse and their children are now identified

3.8.5 Citizen Advice Bureau

3.8.5.1 The only contact that CAB had with either party was when Louise rang the contact centre in Manchester on 13th December 2013 at 16.55 hours and was advised by a triage adviser. She was looking for the names and numbers of legal aid solicitors who could act on her behalf as she had been assaulted by Grant. She was told that legal aid is means tested and that she should contact her civil legal advice, (the number for which was provided to her) who would be able to conduct a legal aid eligibility test and provide her with legal aid solicitors in her area. She was advised to call back if she needed anything further.

3.8.5.2 Whilst the advisor acted in accordance with the remit of the centre, she was not given the Women's Aid number on this first contact. CAB has since reviewed this and in future clients will be given full information at the first call, where appropriate.

The review acknowledges the contact that CAB had in this case was minimal and was conducted in line with their policies at the time. It is noted that changes have been made in light of this case.

3.8.6 District Council

3.8.6.1 It should be noted that in the chronology, contact is referred to as being with the District Council, but the contact was with two separate departments:

- Housing Advice
- Revenues and Benefits

3.8.6.2 The Revenue and Benefits Service is now delivered, on behalf of the District Council, by Compass Point Business Services. The contact with this department was considered under a separate IMR.

[23] The review notes that a written agreement is not now considered good practice in a domestic abuse situation and this would not now be used

3.8.6.3 The first contact made was on 24th February 2012 when Louise phoned as she feared that their house was to be repossessed. In this phone call, she referred to domestic abuse and her husband's alcohol use, and whilst at that time, a DASH risk assessment was not used, in this team there is no record in the file of any professional curiosity, questioning the fear or harm or risk assessment but it does indicate that domestic abuse was discussed.

3.8.6.4 As part of this review, it was noted that during this period there were two case files open, both with a different first name. These files were linked for reference at point of closure.

3.8.6.5 In the second case file, it is clear that Louise attended the council offices for a face to face meeting to review urgent paperwork in relation to the court proceedings for possession. It is possible that, had the earlier information about domestic abuse been known to the person seeing her, additional questions may have been asked and further support offered.

3.8.6.6 As is explained above, the enquiries that Louise made about benefits would have been handled by a different team and it might, arguably, have been useful for each team to understand the involvement of the other to assess the pressures in the household. They would then, again, have been able to ask further questions and offer further support.

3.8.6.7 Whilst it is noted that the professional curiosity was limited, it is clear that the advice provided around the housing need was correct and Louise was signposted to the appropriate support services.

3.8.6.8 It is also noted that DASH risk assessments were not used at the time in this team. This is now in place.

Recommendations

(8) That the case management system and process is reviewed to avoid duplicate records and build in a check of details of other names known by

(9) That the notes are maximised to:

- **a. Capture the detail of the contact;**
- **b. Record the risk assessment;**
- **c. Capture and record supervision action in case notes.**

(10) That there is effective liaison with other services – for example, the risk of domestic abuse that is recorded in the housing files was not shared with Revenue and Benefits.

3.8.7 Compass Point Business Services – Revenue and Benefits

3.8.7.1 The most notable contact with Louise was in July 2014 when, following an investigation of an undeclared bank account, it became apparent that there were fraudulent issues with the benefit claims. It was identified when it became apparent that, over a three-year period, she had failed to advise them of changes of circumstances when Grant was in employment or not living in the home. Therefore, she was receiving benefits to which she was not entitled.

3.8.7.2 Louise was not able to provide a satisfactory explanation for this and she was issued with a formal caution in lieu of prosecution.

The review is satisfied that, during its interactions with Louise, they could not have identified the potential risks in her situation. The review does note that Compass Point Business Services does train its staff around issues such as safeguarding, risk assessment and wider public protection issues, particularly when the interaction is face to face and informal.

3.8.8 South Lincolnshire Domestic Abuse Service (Boston Women's Aid)

3.8.8.1 Louise presented at the drop-in office in Boston on 28th February 2012. She disclosed that there had been domestic abuse for many years, with a history of physical incidents. She said her husband was drinking on a daily basis which made matters worse, along with the fact that he had lost many jobs over the previous few years. Her options were discussed with her, including the rent deposit scheme, seeking legal advice from a local solicitor and accessing a refuge place in Boston.

3.8.8.2 As part of this conversation, her risk was deemed to be low. After a 90-minute appointment, she left the office and said she would make contact once she had been able to process her options. She said it was not safe for Women's Aid to call her at home or at work, as she did not want her colleagues to know what was happening.

3.8.8.3 Louise phoned the office on 7th March 2012 as she was worried that they may go bankrupt and would shortly be losing the house. Refuge accommodation was again discussed with her, but she declined this as her sons were taking their exams and she did not want to disrupt them.

3.8.8.4 Women's Aid identified as discussed at length by the review panel, the difficulty for some professional people to see the reality of the domestic abuse they are experiencing. Whilst she would be familiar with child protection and safeguarding in her professional life, it was, it appeared, difficult for her to translate this into her personal life. This will be discussed in more detail later in the report.

3.8.8.5 The question was raised about the appropriateness of the DASH risk assessment. It was noted that at least 4 of the 27 questions relate to pregnancy and younger children and therefore women who are not in this category will 'lose' out. This could possibly mean that cases are being scored as low risk that should be high risk and therefore be referred to MARAC. It is also noted that, in the main, it is not high-risk cases that are becoming domestic homicides but the medium or low risk cases.

3.8.9 West Yorkshire Police

3.8.9.1 West Yorkshire Police were involved with Grant in the last days of his life when he was in Halifax and arrested twice for drink-driving. During this time, risk assessments and care plans were carried out. On 4th April 2017 he was assessed by a Crisis Team Worker and there was no evidence of any severe or enduring mental health problems and he had no thoughts to harm himself.

3.8.9.2 When he was arrested, rope was discovered in the boot of his car; he was asked about this by officers and was told it was for DIY purposes.

3.8.9.3 Contact was made with his sons, along with the Crisis Team in Lincolnshire and his GP.

3.8.9.4 When Grant was arrested on 4th April 2017 he was initially charged with being drunk in charge of a motor vehicle and he was due to be remanded in custody. When an evidential review was completed, it was decided that there was not sufficient evidence for this to happen. This review should have been undertaken before he was charged, however once this was done, the decision was immediately overturned and plans were made to release him to a supporting caring environment.

The review notes that the IPCC reported that there were no criminal or misconduct issues identified and the appropriate care plans were used on both occasions when he was in custody. They also noted that, whilst there may have been concerns about the rope in the car, the police would have had no powers to seize it in the circumstances.

The review panel noted, when considering this IMR, that good practice had been followed in making contact with the Crisis Team in Lincolnshire to see if he was known to them.

3.8.10 College of West Anglia

3.8.10.1 Grant was enrolled on a four-year BSc (Hons) in Business Management at the college which started in September 2016.

3.8.10.2 There were no incidents involving Grant until March 2017 when, over the course of a few days, there were a number of incidents of behaving inappropriately. On the basis of the final incident, when students reported him for having been drunk in a lecture and drinking and driving, he was immediately suspended pending a disciplinary hearing which obviously did not take place.

The review considers that the college took prompt action when they heard of his misdemeanours and would have addressed these with him.

3.8.11 Addaction

3.8.11.1 There were two separate episodes in which Addaction had contact with Grant.

3.8.11.2 The first episode began on 13th March 2012 when Louise rang to request support for her husband. She was offered a referral to the local family support service which she declined. Grant attended for an initial assessment on 13th March and there were concerns identified relating to aggression or violence. He reported that he had started drinking 6 weeks earlier. He was offered a referral to the Alcohol Community Treatment service which he declined but agreed to 1-1 key working sessions. Contact was attempted in March, May and July but they were unable to make contact and so the case was closed.

3.8.11.3 In their IMR, Addaction identify that there were some significant gaps in the occasions when they tried to contact Grant. Addaction now have a much more assertive DNA (Did Not Attend) policy in place and they will contact people by telephone and letter, using a greater level of professional curiosity especially where families are involved. They also operate an outreach service and offer late night appointments to improve accessibility. Depending on the risks identified, safe and well checks will now be undertaken to contact people.

3.8.11.4 In preparing their IMR, Addaction have noted the discrepancy in Grant's report to them about the level of his drinking and have increased their focus on challenging inconsistencies in the information given by a client about their drinking. Whilst the emphasis is now very much on harm reduction, workers are expected to be more aware of the need to explore the impact of drinking on others in the family and make MARAC referrals as necessary.

3.8.11.5 In 2014, Grant was referred to Addaction as part of his Alcohol Treatment Requirement following the common assault on Louise. This was a requirement to attend 12 1-hour sessions and he was assessed on 29th January as suitable and the first session was set for 14th February which he attended. He then cancelled his session on 7th March without notice and failed to attend on 30th April. When visiting the probation office on another matter, the worker spoke to his probation officer and was told that they had been advised by Louise that he was attending a residential rehabilitation centre in Nottingham. The case was therefore closed.

3.8.11.6 Acknowledging that the paperwork is not complete, there is little to suggest that there was good communication between Addaction and Probation in relation to:

- Sharing risk information;
- Reorganising of appointments;
- Notification of failure to attend on 30th April which would have constituted a breach of his ATR;
- Advising Addaction of his attendance at BetelUK.

3.8.11.7 Since that time, communication between the two services has been formalised. Staff supervision has also been improved in Addaction, becoming more structured and professionally curious to pick up anomalies in the presentation and reported history of a client.

3.8.11.8 Addaction identify, in their IMR, that at his appointment on 14th February, Grant said that his relationship with Louise was under strain and she was placing 'undue stress' on herself. There is, however, no record that this was explored further with him to establish if there were any safeguarding risks. It is now expected that staff will use their professional curiosity to explore situations such as this further, using supervision support and reporting to others if needed.

The review is satisfied that Addaction had identified the shortcomings and have, in place, a more robust service with improved staff training on domestic abuse issues. Addaction Lincolnshire now has a safeguarding lead in each hub site and host daily meetings where concerns can be raised. They now sit on MARAC, ASBRAC and other safeguarding boards.

3.8.12 Humberside, Lincolnshire, North Yorkshire Community Rehabilitation Company[24]

3.8.12.1 Grant first came to the attention of Probation on 28th February 2012 when he appeared in court charged with the offence of driving with excess alcohol. A pre-sentence report was prepared, and he was assessed as suitable for a community disposal with a supervision

[24] Completed on behalf of what was Lincolnshire Probation Trust with the agreement of the National Probation Service

requirement and the Drink Impaired Drivers Programme. However, he stated that he was working in London on a daily basis and therefore not able to attend the course or for supervision. Therefore, a proposal for unpaid work was made and accepted by the court.

3.8.12.2 Although a caution for assaulting his wife was identified in 2011, the main pattern of offending was driving whilst intoxicated. He was assessed as being low risk of further offending in terms of further drink driving offences. He was sentenced to a 12-month Suspended Sentence Order with an unpaid work requirement of 300 hours.

3.8.12.3 He was instructed to complete this unpaid work in a charity shop and he attended on four occasions. On the fifth occasion he attended under the influence of alcohol and was asked to leave. From this point on, he was instructed to attend a work party but did not complete any further hours, providing medical certificates to evidence that he was not fit to work due to chest pains.

3.8.12.4 It was assessed that the order was unworkable and so was returned to court on 27th November. The unpaid work requirement was removed on medical grounds and replaced with a four-month curfew. The case was terminated as there was no further involvement of probation.

3.8.12.5 It was clear that Grant would have benefited from a period of probation supervision and attendance at Drink Impaired Drivers Course, but he told the court he would not be able to comply with this and this was accepted. It is clear that shortly after his court appearance he was not in employment and it seems likely that he used his employment status at the time of sentencing to avoid a sentence that he found intrusive.

3.8.12.6 The probation officer supervising Grant was concerned that his inability to attend unpaid work was influenced by his drinking but, as he provided a legitimate medical certificate, the only option was to return him to court as the order was unworkable.

3.8.12.7 The second time that Grant was engaged with probation began on 28th January 2014 when he appeared in court charged with common assault against Louise. He was sentenced to a 12-month community order with supervision requirement, an alcohol treatment requirement and a specified activity requirement of ten days. The pre-sentence report was prepared by Cambridgeshire Probation Trust[25]. The officer who prepared this report recommended an alcohol treatment requirement but discounted the Building Better Relationships programme on the basis that his behaviour 'appears to have been caused by extraneous factors that can be addressed rather than the difficulties in his relationship.'

> The review acknowledges that Louise would have been required to engage with the Building Better Relationships programme too. We will never know if they would have engaged and what the impact of this might have been but, in the opinion of the review, this was an opportunity missed to provide some intervention in relation to Grant's abuse of Louise.

3.8.12.8 His order was supervised by the same officer throughout, despite the changes that took place in probation in June 2014 and he was assessed as a medium risk of serious harm. A

[25] This was because following the offence he was bailed to a hostel in the Cambridgeshire area

full assessment was undertaken on 24th February 2014, liaising with children's services and Addaction. Liaison took place in the early stages with the social worker who was undertaking the assessment in the home.

3.8.12.9 During the time of his order, Grant self-referred to BetelUK in Nottingham and, although he did not stay there for very long, prompt arrangements were made to have his order looked after by the probation service in Nottingham. Grant fully complied with the terms of his order until it expired on 27th January 2015. At the final assessment, his probation officer expressed concern that he was hiding his alcohol use and therefore would find it difficult to admit to a lapse and seek support.

3.8.12.10 Although Grant complied with his order in terms of attendance, he remained closed to talking about his relationship with Louise. He was extremely resistant to completing any work on a 1-1 basis regarding his relationship with Louise, preferring to focus on his efforts to gain employment.

3.8.12.11 In completing their IMR, an interview was held with the probation officer responsible for supervising this second episode and her reflection, in hindsight, was that she would have tried to do a home visit to the family at an early stage in the order. This was not common practice at the time but now embedded in practice, particularly in relation to child protection and domestic abuse cases.

3.8.12.12 The last involvement with Grant was in January 2015. Since that time, domestic abuse practice has become embedded across probation services (in both the Community Rehabilitation Company and National Probation Service) particularly following the LSCB (Lincolnshire Safeguarding Children Board) domestic abuse audit and the JTAI (Joint Targeted Area Inspection) in December 2016. The actions arising from those inspections are now completed and included in the following (which are relevant to this case):

- Improved communication between probation and domestic abuse police officers, including meetings in the East and West of the county in August and October 2017;
- Refresher domestic abuse and safeguarding training events for all practitioners took place throughout 2017;
- Clear instructions were issued in December 2016 that home visits must take place early on within an order for all cases where there are safeguarding/domestic abuse concerns;
- Internal audits take place on a quarterly basis to ensure that safeguarding/domestic abuse actions are undertaken as required by local policy.

The review is satisfied that there have been significant changes in practice since the time of the involvement with Grant that will have addressed any weaknesses highlighted above

3.8.13 GP for both Grant and Louise

3.8.13.1 Both Grant and Louise saw their GP on numerous occasions over the years that they lived in Lincolnshire. The GP surgery was aware of Grant's drinking but, when triangulated with

other information available to this review, it is clear that he was minimising to the GP the level of his alcohol dependence.

3.8.13.2 With the exception of one consultation when Louise refers to 'hassles' at home there are no other indications of any disclosure of domestic abuse. On this particular occasion on 15th March 2012, the GP recorded that he had a 'long chat' with her. It is not possible from the notes to derive any further information about the content of this consultation.

3.8.13.3 In preparation of this IMR, the GPs have identified a number of recommendations for their surgery. They now have monthly meetings with the multidisciplinary team including social services, physiotherapists and district nurses. Cases that raise safeguarding concerns are flagged at these meetings and formal referrals are made in writing if needed. The referral process for adult safeguarding is now available in all the consultation rooms in the surgery.

Recommendations

(11) That the surgery introduces a policy for adult safeguarding especially domestic abuse

(12) That GPs record in detail any conversations that they have with patients with depression and demonstrate on the record how they have looked at the possibilities of the underlying reason

The review acknowledges that the issues relating to the GP stretch beyond the GP practice in this particular case. Lincolnshire Clinical Commissioning Group has undertaken a number of actions following the recommendations of a previous domestic homicide review including:

- **Delivering Level 3 training in safeguarding adults and children to all GP practices;**
- **Amending this training to explore coercion and control and include a six-minute interview with two sons of a victim of a domestic homicide where they describe how difficult this abuse is to identify and acknowledge;**
- **Instigating a GP safeguarding forum where 'lessons learned' are shared;**
- **Distributing a newsletter to all GP practices which include 'lessons learned'.**

3.8.14 Diocese of Lincoln

3.8.14.1 The Diocese of Lincoln is the Church of England in Greater Lincolnshire. The Diocese consists of more than 600 churches which are centres of worship and community life. A parish church could best be described as a fellowship of Christians who worship together, pray together and form social bonds. As well as formal services, prayer groups and bible studies there are often social events and fundraising activities that take place within a parish context.

3.8.14.2 The family were known to the Diocese because of their involvement with parish church life. Louise particularly was integrated into parish life in both the village in which she lived and a neighbouring small town.

3.8.14.3 The Church does not keep written records of people's attendance at services, social events and bible study groups. Where there are safeguarding concerns, there is an established suite of policies and practice guidance that are followed, and written records are kept. There are no written records kept in relation to the family except in relation to the roles

undertaken by Louise in the church. No member of the church community ever raised a safeguarding concern regarding any member of the family. Louise was held in high regard and, whilst people were aware of Grant's alcohol issues and that there were marital difficulties at different points over the years, there was never a sense that there was significant risk of harm.

3.8.14.4 Current Church of England teaching clearly states that 'The pattern of living that is revealed through Jesus in his relationships with others entails that abuse of any kind is contrary to the will of God and an affront to human dignity. This entails a heavy responsibility upon the Church and its members to do everything possible to prevent or halt it'.[26] Within the current safeguarding guidelines provided for Clergy and laity[27] in responding to disclosures of domestic abuse the point is made that those receiving the disclosure should ensure that their response emphasises that the marriage covenant is broken by the violence of the partner. This has not always been well understood in church environments and thus the Church has been perceived as encouraging partners to stay in violent and abusive relationships. The Church's teaching in this area is the focus of much of the development work being undertaken nationally to which the Diocese has actively contributed.

3.8.14.5 In preparing the IMR, the reviewer has identified that there is a lesson to learn in respect of the need to proactively follow up with anyone who discloses they have experienced harm. Whilst Louise was directed to sources of help and the vicar clearly indicated that she could talk to him about domestic abuse and receive help and support; he did not mention this disclosure again. Whilst he did continue to ask her how she was, he did not specifically follow up on what she had said to him about Grant being violent.

This review is satisfied that the family received support from the church and that they responded with love and both prayerful and practical support. However, the review feels that, when Louise made the disclosure to the vicar about the violence in 2012 this should have been followed up more specifically with her over the following months and years.

3.8.14.6 It has been identified that there is more work to be done, across the Diocese, to move parish communities to a position of understanding that they can engage with statutory partners and be part of the safeguarding community. Some of those who are in ordained ministry, who are churchwardens and those in other roles within the church still view making referrals to statutory agencies as 'a step too far'. Whereas agencies who offer targeted support to vulnerable people in the third/voluntary sector have an established identity in relation to local safeguarding agendas but the church as yet, has not. This is a journey for which small parish churches require support and guidance from statutory partners.

Recommendations

(13) It is recommended that the statutory agencies work closely with the Church to harness the willingness to establish better local relationships and to contribute to a better understanding by agencies of the role of faith communities in the lives of their members. It is recommended that the work begun to have a conversation about the church's teaching on being a 'good neighbour' continues.

[26] House of Bishop's Practice Guidance 'Responding well to domestic abuse', Church House Publishing, March 2017 section 1.2 page 8
[27] Laity means lay people, as distinct from the clergy or ordinary people, as distinct from professionals or experts

(14) It is recommended that the safeguarding boards in Lincolnshire ensure they are engaged with the faith community in their safeguarding processes so that churches can be included in the planning and assessment of families and individuals, recognising that, where people are very involved in their faith life, the church can provide a significant source of support and comfort and that Clergy and Church officers could have active roles in addressing the support needs of their members.

3.8.14.7 In March 2017 the House of Bishop's Practice Guidance on Responding to Domestic Abuse was published. Recommendations for each Diocese were as follows:

- Adopt and publish a domestic abuse statement, including who to contact if there are concerns;
- Appoint a named individual who is a point of contact for any advice and support for Parishes and other Church Bodies;
- Have clear procedures in place to respond to concerns about domestic abuse in line with Section 3 and Responding to Safeguarding concerns against Church Officers Practice guidance;
- Monitor all concerns in relation to domestic abuse allegations and concerns against church officers in the diocese;
- Provide support to Parishes to implement the domestic abuse policy and practice guidance;
- Appoint a Bishop's visitor and ensure that all clergy and their partners know how to access support;
- Deliver domestic abuse training for those in leadership positions, safeguarding and pastoral roles in the diocese and parishes;
- Work in partnership with other specialist agencies.

3.8.14.8 These were adopted by the Diocese of Lincoln immediately and work is underway.

Recommendations

(15) It is recommended that the Diocesan Safeguarding Team completes its Parish Audits during 2018 to enable targeted support to be offered to Parishes who are struggling to mainstream good safeguarding practice within the ministry and mission of the local church

(16) It is recommended that the Domestic Abuse module of the Church of England Safeguarding Training is delivered during the second half of 2018

The review recognises that recruitment is underway to increase the capacity of the Safeguarding Team to enable greater numbers to access training and support.

3.9 Lincolnshire's approach to domestic abuse

3.9.1 As part of the review, the work being undertaken in Lincolnshire to tackle domestic abuse, preventing it by changing attitudes, supporting victims and bringing perpetrators to justice was considered. The Lincolnshire Domestic Abuse Strategy and Delivery Plan, owned by the Lincolnshire Domestic Abuse Partnership, are current (2017-2021), relevant and address these issues. This strategy is attached as an appendix.

3.9.2 These documents are further supported by a comprehensive multi-agency domestic abuse protocol which also covers the areas of prevention, support and enforcement. The stated vision of the protocol is 'to prevent anyone in Lincolnshire suffering domestic abuse'.

3.9.3 This protocol, jointly sponsored by the Domestic Abuse Strategic Management Board, Safeguarding Adults and Safeguarding Children's Boards shows a good level of strategic awareness. It is noted that this protocol is due for review in June 2018 and we would urge that this review is cognisant of the learning from Domestic Homicide Reviews. The Home Office analysis of national trends in relation to domestic homicide but also to be written with a view to the future; looking at the proposals set by government to review and revise the national approach to domestic abuse through a new domestic abuse bill.

3.9.4 In relation to this specific case, we are pleased to see an existing domestic abuse resource pack for schools and educational settings in Lincolnshire. This is well written and a valuable resource for schools. We would urge that all such settings are aware of this pack.

3.9.5 The process for learning from domestic homicide reviews is well embedded through the Domestic Abuse Strategic Management Board and its Delivery Plan.

Section Four - Conclusions

4.1 The review concludes that Louise and Grant's marriage, whilst at times, happy, was over a period of years, subject to controlling, manipulative and violent behaviour by Grant towards Louise. Grant's alcohol misuse played a significant part in their marriage and it is clear that, despite numerous offers of help, he did not engage proactively with any of these but rather, dabbled, on his terms. This is not to excuse his abusive behaviour but to point out that this was how he approached all aspects of his life – it was on his terms.

4.2 We will never know exactly what happened that last weekend, but we believe, for Louise, things were different because never before had Grant had an affair and she told her son that she could not forgive him for this. Both boys believe that, this time, she was really going to leave him for good. However, we know when she visited the vicar the next day she said that, despite the affair, they were going to stay together.

4.3 Despite the involvement over the years with this family, the review is not able to say that the death could have been prevented. All agencies acted appropriately, with the policies they have, in the engagement they had with both Louise and Grant. Whether a different DASH model would have meant she was graded at a higher risk and therefore the situation may have been different is beyond the scope of this review but is reflected in the recommendations.

4.5 The review is satisfied, at the present time, that Lincolnshire is making great efforts to provide support for victims of domestic abuse through a range of different avenues.

4.6 Our thoughts are with the surviving friends and families, especially the two children.

Section Five – Recommendations

Lincolnshire Police

(1) The business case for implementation of Operation Encompass is seriously considered and that the scheme is adopted as soon as possible

Safer Lincolnshire Partnership

(2) It is recommended the Safer Lincolnshire Partnership considers actively encouraging organisations to engage with the available work-place initiatives with a view to improving the support to employees who are victims of domestic abuse

Queen Elizabeth Hospital NHS Foundation Trust, King's Lynn

(3) The Gynaecology Outpatient Clinic and Breast Care Service at Queen Elizabeth Hospital each identify a practitioner to complete the domestic violence champions training

(delivered locally by Norfolk County Community Safety Partnership) and to attend the safeguarding champions' group.

(4) That the Queen Elizabeth Hospital audits whether staff are routinely asking the question about domestic violence and abuse

(5) That the QEH Trust Domestic Abuse Policy is updated to include NICE guidance recommendations

(6) That the safeguarding children and adult team at QEH review the current provision of training around domestic violence and abuse against the NICE Quality Standards 2014

Lincolnshire County Council

(7) That Lincolnshire County Council reviews its absence policy with a view to providing more guidance on the action that should be taken if a member of staff does not comply with the policy and make contact personally. This review should consider how the school and unions can work together to ensure staff understand the need for the safe and well check

The District Council

(8) That the case management system and process is reviewed to avoid duplicate records and build in a check of details of other names known by

(9) That the notes are maximised to:

- Capture the detail of the contact;
- Record of the risk assessment ;
- Capture and record supervision action in case notes.

(10) That there is effective liaison with other service providers – for example, the risk of domestic abuse that is recorded in housing files was not shared with revenue and benefits Department at the time.

GP surgery for Grant and Louise

(11) That the surgery introduces a policy for adult safeguarding especially domestic abuse

(12) That GPs record in detail any conversations that they have with patients with depression and demonstrate on the record how they have looked at the possibilities of the underlying reason

Diocese of Lincoln

(13) That the statutory agencies work closely with the church to harness the willingness to establish better local relationships and to contribute to a better understanding by agencies of the role of faith communities in the lives of their members. It is recommended that the work begun to have a conversation about the churches' teaching on being a 'good neighbour' continues

LSAB/LSCB

(14) That the safeguarding boards in Lincolnshire ensure they are engaged with the faith community in their safeguarding processes, so that churches can be included in the planning and assessment of families and individuals, recognising that, where people are very involved in their faith life, the church can provide a significant source of support and comfort and that Clergy and church officers could have active roles in addressing the support needs of their members

Diocese of Lincoln

(15) That the Diocesan Safeguarding Team completes its Parish Audits during 2018 to enable targeted support to be offered to Parishes who are struggling to mainstream good safeguarding practice within the ministry and mission of the local Church

(16) That the Domestic Abuse module of the Church of England Safeguarding Training is delivered during the second half of 2018