East Staffordshire
Borough Council

East Staffordshire
Community Safety Partnership

OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

"May"

Autumn 2018

Independent Author: Eleanor Stobart

Completed: 18 September 2020

Left Intentionally Blank

May was such a caring, loving and thoughtful person. She absolutely devoted herself to loving and caring for her child, her child was her world. She was so full of enthusiasm and fun and always happy. She never complained about anything and was always so positive towards everything in life.

Words cannot explain how much she is missed.

(May's sisters)

CONTENTS

1. INTRODUCTION

This domestic homicide review was commissioned by East Staffordshire Community Safety Partnership following the death of 'May'. The key purpose of undertaking domestic homicide reviews (DHR) is to identify the lessons to be learnt from homicides 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 himse*lf

In order for lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

This report examined the contact and involvement that agencies had with May, her husband and their child between March 2017 and the time of May's death in the Autumn of 2018. In addition to the agency involvement, this report also examined any relevant past history of abuse and incorporated the views and thoughts of two of May's sisters.

The panel wishes to express their condolences to May's family and friends following her death. The panel would also like to thank all those who have contributed to this review.

1.1. Timescales

East Staffordshire Community Safety Partnership was notified of May's death in September 2018. The Partnership reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and recommended to the chair of the Community Safety Partnership that a domestic homicide review should be undertaken. The chair ratified the decision to commission a domestic homicide review in November 2018 and the Home Office was notified in November 2018. An independent chair was commissioned in November 2018 to manage the process and compile the report. The commencement of the review was delayed partly due to the criminal proceedings and partly because of a delay in receiving the individual management review from the GP Practice. May's family agreed the report in April 2020, but Covid19 caused additional disruption by delaying the report being finalised by East Staffordshire Community Safety Partnership.

1.2. Confidentiality

The findings of this review remained confidential and were only available to participating professionals, their line managers and members of the domestic homicide review panel until after the report was approved by the Home Office Quality Assurance Panel.

To protect the identity of the family members, the following anonymised terms and pseudonyms have been used throughout this review:

May – deceased aged 52

Perpetrator – husband aged 58

Child – aged 12

} Age at the time of May's death

2. THE REVIEW PROCESS AND TERMS OF REFERENCE

The review was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) under s.9 (3) Domestic Violence, Crime and Victims Act (2004).

2.1. Time period

The panel decided that the review should focus on the contact that agencies had with May, her husband and their child between March 2017 and the time of May's death in Autumn 2018. The panel decided on this time frame because this would cover the incident when the perpetrator went missing and include any reported history of abuse and violence within their relationship. The panel agreed, however, if any agency had relevant information outside of this period, this information should be included within the agency's individual management review or information report.

2.2. Contributors to the review

The independent chair wrote to May's family to explain that a domestic homicide review was taking place. They were provided with information leaflets from the Home Office and Advocacy After Fatal Domestic Abuse (AAFDA). Two of May's sisters met with the chair and provided some invaluable information for the panel. Their thoughts and comments are contained throughout the report.

The perpetrator was also sent a letter inviting him to contribute his thoughts. He accepted the invitation and the chair of the review met with him in prison. His thoughts (where relevant) are contained within the body of the report.

2.3. Agencies and other contributors to the review

Individual management reviews and chronologies were requested from:

- East Staffordshire Clinical Commissioning Group (GP Practice)
- Midlands Partnership NHS Foundation Trust
- Staffordshire Police
- University Hospitals of Derby and Burton NHS Foundation Trust

A chronology and information report were requested from:

- Citizens Advice
- School
- West Midlands Ambulance Service

All the authors of the individual management reviews and the information reports were independent of the case i.e. they were not involved in the case and had no direct management responsibility for any of the professionals involved. All agencies included any relevant information about May and her husband as well as their child.

2.4. Key lines of enquiry

The individual management reviews were required to address both the 'generic issues' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- What knowledge or information did your agency have that indicated May might be at risk of abuse, harm or domestic violence and how did your agency respond to this information?
- If your agency had information that indicated that May might be at risk of abuse, harm or domestic violence was this information shared? If so, with which agencies or professionals?
- What knowledge or information did your agency have that indicated the perpetrator was violent, abusive or controlling and might cause harm to someone and how did your agency respond to this information?
- If your agency had information that indicated that the perpetrator was violent, abusive or controlling and might cause harm to someone, was this information shared? If so, with which agencies or professionals?
- Was there anything about their child's presentation that indicated that their child was witnessing domestic abuse or living in a household with domestic abuse? If so, how did your agency support the family?
- Were there issues of capacity or resources within your agency that had an impact on your agency's ability to provide services to May, the perpetrator or their child? Did capacity or resources have an impact on your agency's ability to work effectively with other agencies?

2.5. Review panel

The review panel met three times. All the members were independent of the case i.e. they were not involved in the case and had no direct line management responsibility for any of the professionals involved in the case. The review panel comprised:

- Independent Chair and Author - Eleanor Stobart
- Communities, Open Spaces & Facilities Manager, East Staffordshire Borough Council - Michael Hovers
- Domestic Abuse Lead & MASH[1] Principal Officer, Staffordshire County Council - John Maddox
- Senior Investigating Officer, Major Organised Crime, Staffordshire Police - Detective Chief Inspector Jason Everett
- Family Liaison Officer, Staffordshire Police - DC Mark Astle
- Review Team Specialist Investigations, Staffordshire Police - Mark Harrison
- Designated Nurse for Adult Safeguarding, East Staffordshire Clinical Commissioning Group - Lisa Bates
- Head of Investigations, Midlands Partnership NHS Foundation Trust - Jenny Ball
- Divisional Director Staffordshire, Warwickshire and West Mercia, New Era Victim Services, Victim Support - Melanie Hancox
- Matron Safeguarding Adults University Hospitals of Derby and Burton NHS Foundation Trust - Leanne Millard

2.6. Author of the overview report

The chair and author of this review has been a freelance consultant for 20 years. She specialises in violence against women and girls, safeguarding children and vulnerable adults with a particular focus on domestic abuse and working with minority ethnic families. Eleanor has undertaken research on domestic abuse for Community Safety Partnerships and conducted audits and practice reviews for Local Safeguarding Children Boards. She has chaired and authored over 20 serious case reviews/domestic homicide reviews. Eleanor has a Master of Business and Administration (MBA) from Bradford University School of Management (2000) and a Master of Laws (LLM) in Child Law from Northumbria University (2011).

She is independent of, and has no connection with, any agency in the Staffordshire area; she has never been employed by any agency in the Staffordshire area. Eleanor has completed two previous domestic homicide reviews in Staffordshire but not for East Staffordshire Community Safety Partnership.

[1] MASH (multi-agency safeguarding hub)

2.7. Parallel reviews

Apart from the inquest and criminal proceedings, there were no parallel reviews taking place.

2.8. Equality and diversity

The family is white British. All aspects of equality and diversity were considered throughout this review process including age, disability, race, gender and religion. Where relevant, these issues are referred to within the body of the report. To ensure the review process considered issues around domestic abuse the panel included representatives specialising in domestic abuse. Their thoughts and views are also reflected throughout the report.

2.9. Dissemination

In addition to the organisations contributing to this review (listed in paragraph 2.3), the following will receive copies of the learning from this report:

- Burton and District Mind[2]
- Domestic Abuse Commissioning Board
- East Staffordshire Community Safety Partnership
- Staffordshire Police and Crime Commissioner
- Citizens Advice South Derbyshire and City

3. THE FACTS

Just before 10pm on a Sunday in Autumn 2018, Staffordshire Police was called by a member of the perpetrator's family to inform them that the perpetrator claimed that he had killed May by strangling her. An ambulance crew found May unresponsive. She was confirmed dead on arrival at hospital.

The perpetrator was arrested and charged with murder. Following his trial in June 2019, he was found guilty and sentenced to serve a minimum term of 18 years and 62 days' imprisonment.

[2] Mind is a charity that provides advice and support to empower anyone experiencing a mental health problem. The charity also campaigns to improve services, raise awareness and promote understanding. For further information see www.mind.org.uk – accessed online 5 December 2019

4. BACKGROUND AND CHRONOLOGY OF SIGNIFICANT EVENTS

The perpetrator had been married before and had two adult children. He had one conviction for theft in 1989 after he stole over £3,500 from his then place of work.

May and the perpetrator met when they worked together in Burton. They moved in together around 2000 and had been married for 15 years. The house was privately owned, and both the house and the mortgage were in the perpetrator's name. He was employed at a local supermarket and May was a housewife. Their child was born in 2005 when May was 39 years old. The family was described as "*insular*" i.e. the three of them went everywhere together and did everything together.

Before 2017, little was known by agencies about the family. Then in March 2017, May made a 999 call to the police because the perpetrator had gone missing from home. He left a note stating how much he loved May and their child. He had been experiencing some health problems, and he left home without his medication. He was found by a road worker the following day, who called an ambulance for him. His GP made an urgent referral to Midlands Partnership NHS Foundation Trust (mental health services). As the perpetrator exhibited no signs of acute mental illness, no mood disorder, depression or suicidal intent, he was signposted to the 'Together for Mental Wellbeing' service.[3] When interviewed for this review, the perpetrator explained that he attended six one-hour face-to-face sessions with Mind, which he found very useful.

Another 999 call was made to the police when the perpetrator went missing again on 12 August 2018. On this occasion the police classified him as a high-risk missing person. He had discovered the day before that May was having an affair. He had used her password to gain access to her tablet and had seen messages and photographs that May and the man with whom she was having an affair had exchanged. The perpetrator told May that she and their child would be better off without him and he left the house. He was found a few hours later, having attempted to take his own life by using an overdose of insulin.

He was taken to the emergency department where another referral was made to Midlands Partnership NHS Foundation Trust (mental health services). He was discharged from hospital two days later to stay at his brother's house. He was visited by mental health workers at his brother's house on 16 August and seen at his home on 17 August 2018. By this time the perpetrator felt that he did not require further support and his case was closed.

Nevertheless, he telephoned Midlands Partnership NHS Foundation Trust (mental health services) on 3 September 2018. He asked to be re-referred to mental health services. He was noted to be very distressed and he wanted to speak to someone.

[3] This service works alongside individuals as they overcome obstacles and move forward with their life. This might include (for example) managing mental health, returning to work, solving housing issues and reducing the need for mental health services – for further information see https://www.staffordshireconnects.info/kb5/staffordshire/directory/service.page?id=85-dTQpRSVM accessed online 20 November 2019

He said he was struggling to come to terms with the end of his marriage and was having suicidal thoughts. The perpetrator had an appointment with his GP that afternoon. His GP also called Midlands Partnership NHS Foundation Trust (mental health services) and it was explained that he had an appointment booked for 24 September 2018 and had agreed to telephone support in the meantime.

On 4 September 2018, the Midlands Partnership NHS Foundation Trust (access team) called the perpetrator. He agreed to keep the appointment on 24 September and agreed to contact the access team if he needed to talk or felt at risk. The team called him again on 6 September 2018, he stated that he was feeling more positive and was going back to work. He was discharged from the access team.

During this period, the perpetrator sent the man with whom May was having an affair some abusive and threatening text messages. He threatened to use intimate photographs of the man unless he ended his relationship with May.

Just before 10pm on an evening in Autumn 2018, Staffordshire Police received a 999 to inform them that the perpetrator had killed May by strangling her. Paramedics found May unresponsive and she was confirmed dead on arrival at hospital. The perpetrator was arrested for murder at their shared home. He was remanded in custody. Their child is now cared for by family members.

In July 2019, the perpetrator was convicted and sentenced to a minimum of 18 years and 62 days' imprisonment.

5. THE THOUGHTS OF MAY'S SISTERS

May was the youngest of seven children. She was very close to her mother – as she was the youngest, her mother had more time to spend with her. Her sisters adored her and described how they and their mother spoilt and "*mollycoddled*" May. She was described as "*timid*" and not "*confident*", yet she was very quick witted, funny and she never stopped talking. She was very trusting and never had a bad word to say about anyone (even if they were bad). She was very close to her sisters and they frequently spoke on the phone.

The family explained that May's relationship with the perpetrator was her first serious relationship. His previous wife had left him, and May met him when they both worked in Burton. May gave up working (which her family said she did not appear to mind) because she had arthritis in her shoulders. Her family felt that the effect of May not working was that she became more isolated. At first, they had a car but only the perpetrator could drive. Later it failed its MOT and was not replaced. Again, this isolated May from her family, as he used the excuse of not having a car to avoid family gatherings. May had talked of taking her driving test (she had driving lessons before she met the perpetrator) but she never took the test. She was described as a timid driver.

May had a miscarriage and so when their child was born, the child became the centre of their world – "*everything they did was for* [their child]". May's sisters described how the perpetrator and May kept a chart of everything their child ate,

when their child went to the toilet and how many hours their child slept. May's sisters said this was maintained until the child was about 5 years old. The couple rarely went out and only once was one of May's sisters asked to babysit. Their child was also used as an excuse for not meeting up with May's family, as the perpetrator did not want their child to stay up late and have bedtime disrupted.

Although they bought a house together, it was solely in the perpetrator's name and he paid the mortgage. May was always made to feel that the house was not hers. When the perpetrator attempted suicide for the second time, his family had a "*family meeting*" and then sent May texts telling her to get out of the house before he returned from hospital. Her sisters encouraged her to visit Citizen's Advice and to stay in the property, as she had a pecuniary interest in it.

Her sisters described how May had very little money. She would squirrel away money from the benefits that were paid to her so she could buy presents for her siblings, nieces and nephews. One day, one sister bumped into May whilst out shopping. May was extremely upset because she did not have enough money to buy the perpetrator a Christmas present. Her sister gave her some money.

Some of the "*behaviour*" in the house, May's sisters described as "*odd*". The perpetrator would not let her cook because he didn't want to be "*poisoned*". May had to run their child's bath at 7pm every evening and then run the perpetrator's bath at 8pm. May did everything. She organised all the perpetrator's health appointments, she was "*in-charge*" of his insulin. May's family described the perpetrator as quiet but "*attention seeking*". He used his diabetes to play the victim. He was very dependent on May. After May told him she was leaving, she reassured him that she would help him organise his own hospital appointments, help him with his diabetes etc. before she moved out of the family home. Her sisters were shocked because certain things were "*women's work*" and the perpetrator would not do them.

May had kept in touch with a man that she had been at school with via Facebook. She had coffee with him and told the perpetrator about it. The sisters thought that this coincided with the first time the perpetrator went missing and afterwards he became increasingly more controlling. He appeared to monitor her laptop and mobile and the family also thought that their child was encouraged to monitor May and read her texts. May's family thought that May did not understand about coercive control or economic abuse. As it was her first long-term relationship, she may have thought the perpetrator's behaviour was "*normal*". May's family had not considered the level of control in the household until they thought about it after May's death.

The perpetrator phoned two of May's sisters after he killed her (before either the police or ambulance were called). Both of them had a 'missed call' from him. The family said that he then called the man with whom May was having an affair and told him "*If I can't have her, neither can you*".

6. AGENCY INVOLVEMENT AND ANALYSIS

6.1. Staffordshire Police

On 13 March 2017, May called Staffordshire Police because she thought that the perpetrator had left home to take his own life. He had left a note telling her that he loved her but could no longer carry on. He was suffering from a number of health problems and May was worried because he was diabetic, so he may come to harm if he did not take his insulin. Police recorded him as a high-risk missing person.

In the early hours of 14 March 2017, a road worker called an ambulance because the perpetrator was walking along the edge of a busy road and appeared confused. The ambulance returned him home without the need for hospital treatment. Officers from Staffordshire Police saw the perpetrator on his return home. He explained that he had been feeling low and had decided to take a walk. He had been suffering from tinnitus and it had all become too much for him. He had not tried to harm himself. Police took no further action over the incident.

On 12 August 2018, the perpetrator's sister in law called the police. She had spoken to him and he had expressed to her that he intended to end his life by taking his medication. He had been experiencing marital "*difficulties*". Staffordshire Police then received a call from May. The perpetrator had been in touch with her to say "*goodbye*" to their child. He told her that he had taken all his insulin. He was assessed as a high-risk missing person.

The perpetrator was found in a field by officers nearly three hours later. He was taken to hospital, where his condition was not considered to be life threatening. Police took no further action in connection with the incident.

On both occasions the perpetrator was assessed as a high-risk missing person. On both occasions he was in receipt of medical attention when the police officers arrived. On both occasions the response was prompt and effective. However, there was no record from either event that police took a proactive safeguarding role to ensure that the perpetrator had been referred to mental health services. This was a missed opportunity to ensure that mental health services were aware of him and able to engage with him. In order to demonstrate that officers and staff are appropriately liaising with (and making referrals to) partner agencies, Staffordshire Police should consider undertaking an audit of missing person investigations including how 'prevention interviews' are conducted.

RECOMMENDATION

- Reassurance should be sought by Staffordshire Police that 'prevention interviews' following missing persons episodes consider safeguarding measures and referrals to appropriate services.

6.2. West Midlands Ambulance Service

During the period under review (March 2017 – September 2019), there were three 999 calls made to West Midlands Ambulance Service concerning the perpetrator. On 14 March 2017, a call was made around midnight by a roadworker. The perpetrator had been found walking along a dual carriage way. He appeared confused. When the paramedics arrived, he was sat on the back of the Highways Agency van. He appeared alert and orientated. He had multiple layers of clothing on, he was warm to touch and able to walk. The perpetrator told the paramedics that he was depressed because of having to inject himself daily due to his diabetes. He said he had been out walking since 7.30am. Paramedics took his history, reassured him, carried out monitoring and assessment. He was then taken home. The police and ambulance control were informed. A safeguarding referral was made to the local authority. When the police arrived at the family home, the paramedics left (approximately 2am).

On 12 August 2018 at around 12.30pm, West Midlands Ambulance Service received a call from West Midlands Police concerning the welfare of the perpetrator. May had reported that he had taken all his medication and left the family home. May had spoken to him on his mobile and he said he was "*sorry*" and would be turning his mobile off. All the available police officers were looking for him and they advised the ambulance service that they would contact them if they found him. The ambulance service received another call from the police just before 3pm. Officers had found the perpetrator unconscious in a field. A crew was dispatched and the hospital alerted. He was taken to Queen's Hospital Burton.

The final call to West Midlands Ambulance Service was on an Autumn evening in 2018 just after 10pm. May was in cardiac arrest having been strangled. Life support was commenced and she was taken to Queen's Hospital Burton.

6.3. University Hospitals Derby and Burton NHS Foundation Trust

May had been known at Queen's Hospital Burton since 1994. She had been seen a number of times for general health issues. In 2005, her child was born at the hospital. May was seen twice in 2009 for follow up with the gynaecological team. She had no other contact until the day of her death in September 2018.

The perpetrator was admitted to Queen's Hospital Burton in July 2013 for chest and abdominal pain. He was also seen in the emergency department in February and June 2015 for chest pain, abdominal pain and vomiting. He was admitted for a cholecystectomy later that month. In May 2016, he presented with an eye problem related to diabetes and was seen in the diabetic clinic in January 2017.

During the period under review the perpetrator was seen four times. The first time in March 2017, his GP referred him because he was suffering from tinnitus. The referral stated that he had told his GP that because of the tinnitus he no longer wanted to "*continue with his life*". At the appointment, the perpetrator reported that

the noises were "*driving him to distraction*" and disturbing his sleep. He described the event when he walked away from home and was reported missing.

On 12 August 2018, the perpetrator was brought to the emergency department at Queen's Hospital Burton by ambulance. He had taken an intentional overdose of insulin and other unknown medications. He was admitted into the hospital. It was reported that this was following an "*altercation*" with his wife, having found out she was having an affair. The records stated that he had been upset ever since and remained suicidal. He said the conversation with May had become heated and he became "*agitated*" which led to him taking the overdose. He was described as unsettled and slightly anxious. During his time in the emergency department, a doctor was called to see him. The perpetrator was described as being acutely agitated and causing risk to himself. He was "*lashing out*" and trying to go home. Security was called. He was "*crying and being held by three family members*". He was "*obsessing about May*" and required sedation. Despite his behaviour and obsession with May, it appeared that no one explored their relationship or considered May's or her child's safety.

The perpetrator was referred to the mental health crisis team who reviewed him on 15 August 2018. Following this, he was deemed fit for discharge. He went to stay with his brother on 15 August 2018 with a plan for him to be followed up by mental health services.

In July 2018, Burton Hospitals NHS Foundation Trust merged with Derby Hospitals NHS Foundation Trust to form the University Hospitals of Derby and Burton NHS Foundation Trust. Following this, it became clear that any training that the staff may have received around domestic abuse, had not been implemented into practice. Domestic abuse did not feature in the safeguarding adult training package at that time. Staff were unfamiliar with the DASH (domestic abuse, stalking and honour-based violence) risk assessment or how to undertake a MARAC (multi-agency risk assessment conference)[4] referral. There was very little awareness of domestic abuse. Therefore, the newly configured safeguarding team for University Hospitals of Derby and Burton prioritised harmonising policies and procedures across the hospital sites. All clinical patient-facing staff members are now required to attend level 3 face-to-face safeguarding training.[5] The training includes recognising and responding to domestic abuse as well as risk assessment and making referrals to MARAC (multi-agency risk assessment conference). There are ongoing discussions to incorporate independent domestic abuse advisor (IDVA) services into the emergency department, minor injury units and maternity services. Training has been delivered to clinical teams within these areas of the organisation. Learning sessions have also been delivered to support

[4] A multi-agency risk assessment conference (MARAC) is a meeting where information is shared about high risk victims of domestic abuse. It is shared between representatives of local police, health, child protection, housing practitioners, independent domestic violence advisor (IDVA), probation and other specialists from the statutory and voluntary sectors. The aim is to increase the victim's safety and develop a co-ordinated action plan.

[5] This is in accordance with the Adult Safeguarding: Roles and Competencies for Health Care Staff, Intercollegiate Document 2018 – https://www.rcn.org.uk/professional-development/publications/pub-007069 – accessed online 2 January 2020

staff. To raise awareness of the DASH (domestic abuse, stalking and honour-based violence) risk assessment, awareness screen savers were visible across the organisation for a period in November 2019 and a short video was made available to staff members on the intranet. Domestic abuse posters are being developed in different languages to be placed in all clinical areas. There have also been improvements to IT systems to ensure that information on safeguarding and domestic abuse is easily accessible to staff.

6.4. Midlands Partnership NHS Foundation Trust (mental health)

The perpetrator's first involvement with mental health services at Midlands Partnership NHS Foundation Trust was in March 2017. His GP made an urgent referral due to his low mood. His low mood was as a result of a build-up of health problems over several months. He remained 'open' to community mental health services for six days. The outcome was that there was no evidence of acute mental illness and therefore no role for secondary or primary care services. He was signposted to the 'Together for Mental Wellbeing' service. There was no evidence that he ever approached or engaged with this service. However, when interviewed for this review, he explained that he attended six one-hour face-to-face sessions with Mind, which he found very useful.

There was no further contact with mental health services until August 2018. Liaison psychiatry received a referral from Queen's Hospital Burton because he had taken an intentional overdose. He disclosed that his wife was having an affair and this led to an argument. He explained that on discharge from hospital he would be staying with his brother for a few days. He denied that he was a risk to himself, but he agreed to three days of support and assessment from the 'crisis resolution home treatment' team.

During the three days of support from the crisis resolution home treatment team, he spoke of his regret at taking an overdose. He said he had no further plans, thoughts or intent to self-harm. He acknowledged and accepted that his relationship with May was over. He said he intended to return home and remain there. He felt he did not require further support from mental health services and his care was transferred back to his GP.

On 3 September 2018, the perpetrator self-referred to mental health services. He wanted support because of his low mood and suicidal ideation. He gave the reason as his marriage ending. He denied any immediate risk to himself (thus the crisis resolution home treatment team was not indicated) so he was given an appointment for 24 September 2018 with the 'non psychosis pathway' team. During the assessment, he was asked not only about harming himself but also about harming others. He admitted sending an "*abusive*" text message to the man with whom his wife was having an affair, but he said he had no intention of acting on it (the actual text of the message was unknown to mental health services).

The 'access' team made support calls to the perpetrator on 4 & 6 September 2018. On the second call, the perpetrator stated that he was feeling more positive and

said he no longer required support and would wait for his appointment. In the meantime, he was aware of the 24-hour support services should he need them.

Throughout the documentation, it stated that the perpetrator hoped to maintain an amicable relationship with May and there was no evidence from any of the assessments that he might pose a risk to others – or that he was at risk of harm from others, drugs, alcohol or self-neglect. Nevertheless, there was nothing documented to suggest that there was any family involvement in his care or that their opinions were sought. The Trust does have 'Carer Engagement Standards' as well as a 'Our Service User and Carer Charter'. These set out the need to engage with carers in the assessment process (where possible). It gives carers the opportunity to discuss any concerns in relation to their 'significant other'. Assessments should identify who is the service user's carer and whether consent has been given to share information. When consent is not given, staff need to be aware that this does not mean the Trust cannot engage with carers. The Trust is still able to ask for their views on progress and allow carers the time to express their thoughts and feelings.

RECOMMENDATION

- Midlands Partnership NHS Foundation Trust should evidence that clinical staff are adhering to the Carer Engagement Standards as well as the "Our Service User and Carer Charter".

6.5. General Practitioners

The perpetrator, May and their child were all registered at the same GP Practice. May was not a frequent attender. In fact, she had only attended seven times for non-specific health issues since the birth of her child in 2005. During the period under review May attended once (May 2018) for a medication review of an unrelated condition. None of her attendances indicated any signs of domestic abuse.

May's child had been registered at the GP Practice since birth. Apart from the child's normal immunisation programme, the child had only accessed health services once for a minor common childhood condition in 2016. The child had no contact with the GP Practice throughout the period under review. There was nothing documented in the child's records to indicate that the child might be living in a household with, or witnessing, domestic abuse.

The perpetrator had been registered with the GP Practice since 1999. He had a number of health conditions including insulin dependent type 2 diabetes which he had been diagnosed with in 2013. He had hypertension (high blood pressure) which was diagnosed in 2015 and he had hypothyroidism (under active thyroid gland) which was diagnosed in 2017.

The perpetrator had an episode of depression in March 2017. He was discovered by workmen in a confused state. The workmen called the West Midlands Ambulance and an ' adult safeguarding concern ' was raised. The GP Practice completed a responsive home visit the same day. An urgent referral was made to

the Community Mental Health Team, he was prescribed a short course of anti-depressants, a two-day follow up appointment was booked at the GP Practice and an initial diagnostic screening was completed. The responsive visit documentation was exemplary and demonstrated a good and prompt approach to the situation. He did not disclose any domestic concerns at the time, but he did say that there were pressures at work.

The perpetrator was seen regularly by the GP Practice for reviews between March and June 2017. Sometimes he was seen on his own and sometimes with May. He started a phased return to work at the end of June 2017 and this coincided with the discharge from Mind following six counselling sessions. The discharge notification from Mind showed that he had been seen for anxiety and depression. He was discharged from the service due to the treatment being complete with a marked improvement on the scoring system (for anxiety and depression).

The perpetrator was seen on 29 January 2018 with a viral illness. He was accompanied by May. There was no reference to any further concerns or discussion about his mental state.

He was offered an appointment for diabetic screening on 15 June 2018. He declined it, as he was having on-going support for his diabetes from Queen's Hospital Burton. There were regular detailed reports from the diabetic nurse specialist to the GP Practice.

On 16 August 2018, the GP Practice received a discharge report from Queen's Hospital Burton. It concerned the perpetrator intentionally overdosing on insulin four days earlier. He had been discharged with the support of his brother and the crisis team because of his low mood and associated risk. His records showed that there was a request by the crisis team for a patient history on 15 August 2018. This was provided the same day which showed a timely response by the GP Practice. Nevertheless, there was a delay of two days in informing the GP Practice of his discharge from hospital.

The perpetrator was seen at the GP Practice on 20 August 2018. He explained that his wife's affair was the reason for his overdose. He said that his mood had improved and had a more positive outlook for the future, and he accepted that his marriage was over. The GP had a "*supportive discussion*" with him and the perpetrator described a positive experience of the crisis team and said that his family were supporting him.

On 3 September 2018 the GP Practice recorded that a referral was made for the perpetrator to the Community Mental Health Team. It was also recorded that May contacted the GP Practice because she was concerned about his "*rapidly declining mental state*". The consulting GP spoke to the perpetrator over the telephone and he confirmed his mood had dropped because his marriage had broken down. The perpetrator explained that he had contacted the crisis team independently and was waiting for a call back. He agreed to go to the GP Practice that day for a further consultation. During his appointment he disclosed that he had considered taking his own life the previous day (when he had stood by the side of the road and a lorry was passing). He stated that he did not feel that way now, but

he could not guarantee that he would not feel like that again because he was not coming to terms with the end of his marriage. He expressed frustration that he had been given an appointment three weeks into the future (24 September 2018) to see the crisis team. The GP therefore contacted the service to arrange for the Access Team to contact the perpetrator that evening. This was the final face-to-face consultation prior to May's death.

The GP records demonstrated a therapeutic relationship with the perpetrator with both pro-active and re-active timely referrals for his physical and mental health concerns. At each contact the GP documented the support systems in place, assessed his level of anxiety and ensured a further follow up was planned and agreed. The perpetrator's records showed good engagement between all health partners, however, the discharge notifications were sometimes delayed, absent or had little detail. High quality discharge notifications are essential for effective information sharing.

The GP engagement with both May and her child did not raise any concerns. There was never any indication of domestic abuse or disclosure of control or coercive behaviour. The only potential opportunity to discuss May's relationship with the perpetrator was when she phoned the GP Practice on 3 September 2018. Nevertheless, at the time everyone's concern was focused entirely on the perpetrator (as the victim of his wife's infidelity). This was potentially a missed opportunity to explore the dynamics of their relationship.

The GP Practice has up-to-date safeguarding training, policies and procedures. Yet there was no recorded evidence of any exploration into the possibility that the perpetrator's threats of suicide might be a form of coercive control and that he might have been trying to manipulate May to stay in the relationship. There appeared to be an escalation in his attempts to take his own life and an escalation in his threats of further attempts. The correlation between separation and domestic homicide are well documented. The GP Practice however did not appear to question either May's or her child's personal safety and well-being when May phoned concerned about the deterioration in his mental health.

Despite the advice in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016), some GP Practices remain reluctant to release perpetrators' records without their consent. This causes significant delays in producing chronologies and individual management reviews. This could also potentially delay lessons from being learnt and delay any change in practice that could reduce the risks to others.

RECOMMENDATIONS

- It should be standard practice that when the threshold for a domestic homicide review is met, a letter should be sent on behalf of the independent chair to request access to the perpetrator's medical records
- The adult safeguarding training delivered by the Clinical Commissioning Group to primary care staff on domestic abuse should include coercion and

control. This should be evidenced by research findings such as 'Counting Dead Women' [6]and 'Partner Femicide.[7]

- The GP Practice should seek additional support and training on domestic abuse, and it should include the signs of coercive control. This will ensure that the staff are aware of their duties to explore and document discussion following disclosures such as marital breakdown.

6.6. Burton and District Mind

Burton and District Mind received a self-referral request from the perpetrator following a visit to his GP. Mind completed a counselling assessment with him on 7 April 2017. During this assessment he discussed his lack of acceptance on being diagnosed with diabetes two years before and how this had drastically changed his life. He disclosed that he had gone missing from home for 15 hours without his insulin and at that point had experienced suicidal thoughts. He discussed that he had received support from the Community Mental Health Team and had not experienced these thoughts since. He also expressed constant worry and anxiety.

Psychometric measures were taken using the personal health questionnaire (PHQ 9) [8] and the generalised anxiety disorder assessment (GAD 7).[9] His scores indicated that he had severe depression and anxiety at the beginning of the counselling sessions. He provided no information to suggest that there was anything troubling him about his family and relationships. He was however described as not being self-aware and he was unable to fully explore his feelings. It was not clear whether he 'could not' or was 'unwilling' to explore his feelings. He was discharged from the service at the end of June 2017, having attended six face-to-face sessions. By this time, his depression and anxiety were considered mild.

6.7. Citizens Advice

An information report was sought from Citizens Advice Mid Staffordshire, but the service closed on 31 March 2019. The panel nevertheless was given access to documents and records concerning May. The records showed that May sought advice from Citizens Advice was on 14 August 2018. She told the advisor that she was married and had a 12-year-old child. They were living in a mortgaged property, but the house and mortgage were in her husband's name only. May explained that she did not work but she did receive child tax credit and child

[6] Ingala Smith, K (2018) Counting Dead Women www.kareningalasmith.com/counting-dead-women accessed online 5 December 2019

[7] Monckton Smith, J (2019) Intimate Partner Femicide: using Foucauldian analysis to track an eight stage relationship progression to homicide accessed online 5 December 2019

[8] PHQ 9 is a tool used to monitor the severity of depression and response to treatment. For further information see https://patient.info/doctor/patient-health-questionnaire-phq-9 - accessed online 20 Nov 2019

[9] The GAD 7 is a questionnaire used as a screening tool and severity measure for generalised anxiety disorder For further information see https://patient.info/doctor/generalised-anxiety-disorder-assessment-gad-7 – accessed online 20 November 2019

benefit. She said that her husband paid the mortgage and she paid the gas, electric and internet bills out of the child tax credit.

May explained that she had told her husband that she wanted to separate from him, and he had taken an overdose and was in hospital. May had no information about his medical condition, as her access to him had been "*blocked*". May said that it was her "*fault*" that he took the overdose, because she wanted to end the relationship. May stated that there was no abuse in the relationship – although it was not clear from the documentation what questions she was asked to ascertain this information.

May explained that her husband's family was blaming her and wanted her out of the marital home as soon as possible. He was due back from hospital but she was not sure when and his family wanted her "*gone by the time he returned*". May said she had no money and had very little food in the house. May wanted advice about finding alternative accommodation for her and her child. She wanted to know what benefits she could apply for because her child needed new shoes and she had bills to pay. She said she needed money urgently.

May was given an appointment on 21 August 2018 but she asked for benefit advice sooner. She was offered a telephone call within 3 – 4 days but she decided that she would rather attend the appointment instead. May was informed that she could go to the food bank at the YMCA if she could not afford to buy any food. The advisor asked May whether she could leave a message at the hospital to ask "*permission*" to withdraw money for food and bills from her husband's bank account. May did not want to do that and said that she could not ask her family or his family for money to buy food either.

May attended her meeting on 21 August 2018. Her circumstances had changed since the previous contact. She said that she was now living with her husband and their child at the marital home and her financial position was "*stable*". She had decided not to seek a reconciliation, not to remain in the marital home but instead to make arrangements to leave with her child and move into rented accommodation or social housing. May said she had approached Trent and Dove Housing and was awaiting a response (there was no evidence that May had approached them).

May said that she and her husband had no joint debts or joint bank accounts. She had no assets and received child benefit and child tax credit directly. May wanted to establish financial credibility and she planned to do this by applying for job seekers allowance. If she could afford a rental property, she could claim housing benefit and council tax reduction. The advisor established that they both had parental responsibility and advised that they would both need to agree on all issues relating to their child. The advisor explained that May's husband would need to pay maintenance. May said that at this stage, she was not seeking a divorce. The advisor concluded that May was going to remain in the marital home and was receiving full financial support. She had time to plan and "*execute*" an independent existence and find an alternative property. The advisor explained to May that if her circumstances changed, she could return for further advice.

As the Citizens Advice Service closed in March 2019, it was not possible for them to provide an information report with any analysis of the service that was provided to May. The panel would have liked to know what questions May was asked about domestic abuse for example:

- Did both she and her husband have equal access to the household income?
- Why the mortgage and house were solely in her husband's name?
- Whether she was allowed to work?
- Was she able to drive?
- Was she ever prevented from seeing her friends or family?
- Could she go where she wanted, when she wanted?

This was potentially a missed opportunity to explore the dynamics of the household. It was the only time that May appeared to demonstrate that all was not well in her relationship with the perpetrator. It would have been useful to know what training advisors at Citizens Advice receive around domestic abuse, coercive control and economic abuse.

RECOMMENDATION

- East Staffordshire Community Safety Partnership should write to the Executive Director of Operations at Citizens Advice (enclosing a copy of the final report) to ask them to review whether their advisors receive appropriate training on domestic abuse (including information on coercive control and economic abuse).

6.8. School

Their child attended a school in Burton on Trent from September 2017. Their child was described as a pleasure to teach. Their child's attendance in the first year was 372 out of a possible of 374. Their child had no unauthorised absences and was making good progress with schoolwork. Their child had a small social circle and did not appear to be isolated in any way. There was nothing about their child's appearance, behaviour or achievement to suggest that their child was distressed at home. There were no indications that their child was living in a house with (or witnessing) domestic abuse. Both parents had attended the parents' evening. They presented as a tight-knit family and there were no safeguarding concerns.

7. EMERGING THEMES

7.1. Recognising and understanding coercive control

Although there had not been any previous call-outs to police, research shows that on average, female victims are subjected to 35 incidents of domestic abuse before they involve the police.[10] There was no information within the review to show that

[10] See for example https://www.refuge.org.uk – accessed online on 20 November 2019

the perpetrator was violent towards May. Nevertheless, it was clear he was controlling. There was nothing documented to indicate whether May had been spoken to by professionals (GP, mental health or police) in order to ascertain her views about what had happened when her husband went missing or attempted to take his own life. Research shows that threats or attempts at suicide by a perpetrator are a clear risk factor in domestic homicide. "*Has he ever threatened or attempted suicide*" is a question on the DASH (domestic abuse, stalking and honour-based violence) risk assessment. In fact, research suggests that many domestic homicides take place in the context of "*male dominance and control which is manifested in possessiveness, extreme jealousy, attempts to isolate the women, threats of suicide, and threats to kill that are often triggered by loss of control due to impending separation or real or imagined infidelity*".[11] Indeed, the "*Controlling or coercive behaviour help guide*" developed by Staffordshire Police cites threats of suicide by the abuser as an aspect of coercive control.[12] Women's Aid [13] provides some common examples of coercive behaviour which includes:

- Isolating you from friends and family
- Depriving you of basic needs, such as food
- Monitoring your time
- Monitoring you via online communication tools or spyware
- Taking control over aspects of your everyday life, such as where you can go, who you can see, what you can wear and when you can sleep
- Depriving you access to support services, such as medical services
- Repeatedly putting you down, such as saying you are worthless
- Humiliating, degrading or dehumanising you
- Controlling your finances
- Making threats or intimidating you

It was clear from speaking with May's family that she was subjected to a number of the examples of coercive controlling behaviour listed above. She did not work, and she could not drive, which both contributed towards her being isolated from friends and family. Her communications appeared to be monitored and she did not have equal access the household income.

7.2. Recognising and understanding economic abuse

It is not clear whether May really understood the concept of either coercive control or economic abuse. Although the Government definition of domestic abuse[14]

[11] See for example, Johnson H et al, Intimate femicide: The role of coercive control, Feminist Criminology (2017) – accessed online 20 November 2019
[12] Controlling or coercive behaviour help guide: We're on your side, Staffordshire Police – accessed online 20 November 2019
[13] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/ - accessed online 20 November 2019
[14] See for example https://www.gov.uk/government/news/new-definition-of-domestic-violence - accessed 28 October 2019

incorporates economic abuse, often victims may have little understanding of what this means. Sharp's research[15] concludes that economic abuse is complex. Economic abuse is described as when "*someone interferes (through control, exploitation or sabotage) with their partner's ability to acquire, use and/or maintain economic resources. Economic resources include money, housing, transportation, and utilities such as heating or items such as food or clothing*".[16] In May's case, it was evident that the couple met when they worked together in Burton on Trent. Nevertheless, May no longer worked, and she was described as a housewife by the time of her death. She told Citizen's Advice that she received tax credit and child benefit into her account and that money paid for the gas, electric and internet bills. Whilst their house and mortgage were in her husband's name only. There were no joint bank accounts.

Sharp identifies four different types of financial abuse:[17]

- Interfering with employment
- Controlling access to financial resources
- Refusing to contribute to financial costs
- Generating financial costs

We do not know for certain what May's experience was, but we know that perpetrators may demand to know how money is spent and make a victim continually ask for money. They may refuse to contribute to the household bills whilst spending money on other things and building up debt for the victim. It is common to see financial sabotage i.e. not letting the partner work. Inevitably, these all contribute to making the victim more dependent on the perpetrator. Studies show that women are three and a half times more likely to suffer domestic abuse if they cannot find £100 at short notice.[18] It was clear from May's conversation with Citizen's Advice and from the chair's discussion with the perpetrator that May did not have access to money or enough money to leave.

[15] See for example: Dr Nicola Sharp-Jeffs "Supporting Survivors of Financial Abuse: Learning for the UK, 2016

[16] https://survivingeconomicabuse.org/economic-abuse/what-is-economic-abuse/ - accessed online 20 November 2019

[17] Sharp, N. (2008) "What's Yours is Mine" The different forms of economic abuse and its impact on women and children experiencing domestic violence. London: Refuge – also see Postmus, J. L., et al (2012) Understanding Economic Abuse in the Lives of Survivors Journal of Interpersonal Violence. 27(3) 411-430

[18] Walby, S. and Allen, J. (2004) Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey London: Home Office Research Study 276 cited in Sharp-Jeffs, N (2016) "Supporting Survivors of Financial Abuse: Learning for the UK

7.3. Domestic abuse and the danger of separation

The perpetrator's coercive controlling behaviour and the economic abuse that May suffered made her more vulnerable, especially when she decided to end her relationship with him. Leaving an abusive partner can be very dangerous. Research[19] shows that women are at greater risk of violence and being killed after separating from abusive partners.

Mental health services, the GP Practice and staff at the emergency department were aware that the marriage had broken down. During this period, the focus of health professionals was always on the perpetrator and his deteriorating mental health, rather than the risk he may pose to May and their child. From records it was unclear whether Citizens Advice explored May's relationship with her husband or understood how vulnerable she might be when separating from him.

It appeared that he managed to persuade May to stay until she found other accommodation. May told her family that they were trying to keep the separation amicable. The perpetrator may have used the deterioration in his mental and physical health to persuade May to stay but she had told family members that she was only staying until she had saved some money and arranged other accommodation for herself and her child. She also told family members that she had reassured her husband that she would not leave until she had taught him how to make his own appointments and manage his diabetes.

One of May's sisters asked May whether she thought the perpetrator might harm her but May said she was sure he would never hurt her.

7.4. CSP Recommendation

At the sign off stage for this report the Community Safety Partnership felt that lessons from this review should be embedded on a wider footprint for the County. Therefore, they added a further recommendation for a strategic assurance approach covering the coercion, control and financial abuse issues with a focus on the wider VCSE sector. The Domestic Abuse Commissioning and Development Board was considered the most appropriate place to deliver on this requirement.

RECOMMENDATION

The Domestic Abuse Commissioning and Development Board should assure the East Staffordshire CSP that awareness of domestic abuse (especially coercion & control and economic abuse) is being enhanced across a wide landscape of agencies particularly the Voluntary, Community and Social Enterprise (VCSE) community. This should further safeguard their service users and the public, in line with the findings of this review.

[19] See for example Refuge Website: Forms of violence and abuse - barriers to leaving; www.womensaid.org.uk/domestic-violence-articles.asp?section=00010001002200020001&itemid=1126 and www.femicidecensus.org.uk The Femicide Census; 2017 Findings – accessed online 20 November 2019

8. RECOMMENDATIONS

i. East Staffordshire Community Safety Partnership should write to the Executive Director of Operations at Citizens Advice (enclosing a copy of the final report) to ask them to review whether their advisors receive appropriate training on domestic abuse (including information on coercive control and economic abuse).

ii. Midlands Partnership NHS Foundation Trust should evidence that clinical staff are adhering to the Carer Engagement Standards as well as the "Our Service User and Carer Charter".

iii. Reassurance should be sought by Staffordshire Police that 'prevention interviews' following missing persons episodes consider safeguarding measures and referrals to appropriate services.

iv. It should be standard practice that as soon as the threshold for a domestic homicide review is met, a letter should be sent on behalf of the independent chair to request access to the perpetrator's medical records.

v. The adult safeguarding training delivered by the Clinical Commissioning Group to primary care staff on domestic abuse should include coercion and control. This should be evidenced by research findings such as 'Counting Dead Women' [20] and 'Partner Femicide'.[21]

vi. The GP Practice should seek additional support and training on domestic abuse, and it should include the signs of coercive control. This will ensure that the staff are aware of their duties to explore and document discussion following disclosures such as marital breakdown.

vii. The Domestic Abuse and Commissioning Development Board (DACDB) should seek assurance that training and development in relation to domestic abuse for GPs is meeting its objectives. The specific areas of development include coercion and control, escalation of risk linked to recent studies around the preceding steps to domestic homicide.

viii. The Domestic Abuse Commissioning and Development Board should assure the East Staffordshire CSP that awareness of domestic abuse (especially coercion & control and economic abuse) is being enhanced across a wide landscape of agencies particularly the Voluntary, Community and Social Enterprise (VCSE) community. This should further safeguard their service users and the public, in line with the findings of this review.

[20] Ingala Smith, K (2018) Counting Dead Women accessed online 5 December 2019
[21] Monckton Smith, J (2019) Intimate Partner Femicide: using Foucauldian analysis to track an eight stage relationship progression to homicide accessed online 5 December 2019