Domestic Homicide Review Report

Under s9 of the Domestic Violence Crime and Victims Act 2004

Two deaths in Norfolk

July 2016

Report Author: Christine Graham

September 2017

Preface

Norfolk County Community Safety Partnership wishes at the outset to express their deepest sympathy to families of Stephanie and Mark Johnson, particularly to their parents and children. 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 Norfolk County Community Safety Partnership on receiving notification of the deaths of Stephanie and Mark 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 two deaths. HM Coroner has held the inquest into Stephanie's death and recorded a finding of unlawful killing. At the time of writing, the inquest into the death of Mark has not yet been held, HM Coroner having decided to adjourn the inquest until after this review has been completed.

Glossary

DHR	Domestic Homicide Review
DHR1	Standard form used by Norfolk County Community Safety Partnership for written notification that a death has occurred which may meet the criteria for a Domestic Homicide Review
IMR	Individual Management Review
MAPPA	Multi-Agency Public Protection Arrangements
NCCSP	Norfolk County Community Safety Partnership – this is a statutory partnership comprising agencies serving the county and is responsible for community safety within the county

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Section One – Introduction

1.1 Summary of circumstances leading to the Review

1.1.1 At around 1 am in mid-July 2016 police received a call from the ambulance service to say that they had been called following a report that a male had shot himself in a village in Norfolk.

1.1.2 On arrival police found Mark Johnson dead in the front garden of the premises. There was a shotgun near his body.

1.1.3 On checking the inside of the bungalow Stephanie Johnson was found dead in one of the two lounges. She too had been shot.

1.1.4 An investigation was launched by Norfolk and Suffolk Police Major Investigation Team. The inquiry concluded that no third party was involved in the deaths and that all the evidence showed that Mark had shot Stephanie before turning the shotgun on himself. A full report was prepared for the coroner.

1.1.5 Early in 2017, HM Coroner held an inquest into the death of Stephanie Johnson and returned a finding of unlawful killing.

1.1.6 HM Coroner has, at this stage, not finalised the inquest into Mark's death.

1.1.7 The Domestic Homicide Review Panel subsequently decided that this Review should consider the deaths of both Stephanie and Mark.

1.2 Reason 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.

1.2.2 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 all of the evidence suggests that Mark Johnson took the life of Stephanie Johnson and then took his own life. Therefore, the criteria for a review was met.

1.2.4 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to 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 July 2016 Norfolk County Community Safety Partnership (NCCSP) was advised by Norfolk Constabulary that the deaths of Stephanie and Mark had occurred.

1.3.2 On 4th August 2016 a DHR Partnership meeting was held chaired by the Chair of the NCCSP. 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 8th August 2016 the Home Office was informed of the decision to hold a review. The families were informed of the review.

1.3.5 On 15th November 2016 the Coroner was advised of the Domestic Homicide Review. The partnership has acknowledged that the length of time before the Coroner was informed about the review was too long and the procedures in Norfolk have now been amended to ensure that, in future, the Coroner will be informed as soon as the Partnership Group makes a decision to hold a 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 16th December 2016. For the benefit of those involved in a review for the first time the process and purpose of the review was explained. The following organisations were represented at the meeting:

- Norfolk Constabulary
- Office of Police and Crime Commissioner

- Norfolk County Council
- King's Lynn and West Norfolk Borough Council
- Ormiston Children and Families
- Leeway
- Norfolk and Waveney Clinical Commissioning Groups
- Queen Elizabeth Hospital, Kings Lynn
- NHS England
- Representative from the Stephanie's GP surgery

Apologies were received from:

- Norfolk Safeguarding Adults Board
- Norfolk and Suffolk Foundation Trust
- MAPPA Co-ordinator

1.3.8 At this first meeting, the Panel considered the composition of the Panel and agreed that it brought together relevant expertise in relation to the particular circumstances of this case.

1.3.9 The meeting confirmed the view that, in light of the circumstances prevailing in the case, the Domestic Homicide Review would consider the deaths of both Stephanie and Mark.

1.3.10 The meeting agreed that Individual Management Reviews (IMR) would be completed by:

- Norfolk Constabulary
- GP for both Stephanie and Mark[1]

Written summaries would be provided in relation to:

- Hospital treatment overview for Stephanie and Mark
- Low level anti-social behaviour incidents reported to King's Lynn and West Norfolk Borough Council

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

1.3.11 The review concluded early in September 2017.

1.4 Confidentiality

1.4.1 The content and findings of this Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the Review has been approved for publication by the Home Office Quality Assurance Panel.

[1] Mark's GP met with the Chair and Report Writer and notes taken of that meeting were agreed by him. He was then asked, by email, for some points of clarification. Following consideration of the draft report by the Panel the Report Author had a face-to-face meeting again with the GP to address the matters raised by the Panel. He did not present his information in the IMR template, as it was felt by the Chair that the approach adopted would engender better co-operation.

1.4.2 In order to protect the identity of victims and their family members, the following pseudonyms have been used:

Female victim: Stephanie Johnson, who was 48 years old at the time of her death
Male perpetrator: Mark Johnson, who was 47 years old at the time of his death

Both were white British. They were married at the time of their death and each had adult children from previous relationships.

1.5 Dissemination

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

- Stephanie family
- Mark's family
- Norfolk Police and Crime Commissioner
- Chief Constable, Norfolk Constabulary
- Chief Executive, Borough Council of King's Lynn and West Norfolk
- Chief Executive Officer, Leeway Domestic Violence and Abuse Service
- Chief Executive Officer, Norfolk and Waveney Clinical Commissioning Groups
- Chair, Norfolk Health and Wellbeing Board
- Chair, Norfolk Domestic Abuse and Sexual Violence Board
- Independent Chair, Norfolk Safeguarding Adults Board
- GP practice for Stephanie and Mark
- NHS England Midlands and East (East)
- Members of the Norfolk County Community Safety Partnership
- Senior Coroner for Norfolk

1.6 Terms of reference

1.6.1 The terms of reference were agreed by the Review Panel on 16th December 2016. It was at this meeting that it was agreed that the Domestic Homicide Review would consider the deaths of both Stephanie and Mark Johnson.

Terms of Reference for the Domestic Homicide Review into the Deaths of Stephanie Johnson and Mark Johnson

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Norfolk County Community Safety Partnership (NCCSP) in response to the death of Mark Johnson and Stephanie Johnson early in July 2016.

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 NCCSP has appointed Gary Goose to undertake the role of Independent Chair and Overview Report Author for the purposes of this review. Mr

Goose will be supported by Christine Graham. 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 in July 2016 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 in July 2016; 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 the evening could reasonably have been predicted or prevented.

4.2 Consider the period of from 1st January 2003 to the date of the incident 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 that summarises the chronology of the events, including the actions of relevant agencies, analyses and comments on the actions taken, and makes 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 on 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 issues emerging.

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.

1.7 Methodology

1.7.1 Norfolk County Community Safety Partnership was advised of the deaths by Norfolk Constabulary early in July 2017. This was by way of a DHR1 report. 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 DHR meeting was held on 4th August 2016. This was chaired by the Chair of the NCCSP. At this meeting, the police provided a summary of the incident and partners present shared the initial information that they held in relation to both victims. At this point it was believed that there was no history of domestic abuse and neither the victim nor the perpetrator were known to domestic abuse services. The GP for the perpetrator confirmed that he had seen Mark on the day of the incident.

1.7.3 Having heard the input from partners, the Chair made the decision to hold the Domestic Homicide Review because, while there was no information regarding abuse between the

couple, the circumstances clearly met the requirements of the guidance and it was felt likely that learning may be established that would increase the understanding of abuse within the county and make others safer in the future. This decision was made within one month of the deaths and therefore complied with the statutory timescale for making the decision. The Home Office was informed of the decision to undertake to a review. This decision demonstrates a good understanding by the Chair of the Partnership of the issues surrounding domestic abuse and a willingness to welcome external scrutiny of the case in order that lessons could be learnt.

1.7.4 Gary Goose and Christine Graham were appointed to carry out the review, as Independent Chair and Overview Report Author respectively. The Review Panel met for the first time on 16th December 2016. It was agreed that Individual Management Reviews would be undertaken by the police and both GPs. A written summary of contact would be provided by the Queen Elizabeth Hospital, and by the local authority in relation to any reports of anti-social behaviour. The Terms of Reference were agreed subject to the families being consulted. It was agreed that the Independent Chair and Overview Report Author would make contact with both families with an introduction via the police family liaison officers.

1.7.5 The Panel met again on 28th March to review progress, consider the information learned to date, set the continuing strategy for the Review and add challenge and rigour to the process. The Panel met, to consider the final report, on 2nd June 2017. The final meeting of the Panel was on 24th August 2017.

1.7.6 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.

1.7.8 The Chair and Overview Report Author met with Mark's children on 23rd January 2017 and Terms of Reference and Home Office leaflets were shared.

1.7.9 Following the meeting with Mark's children a meeting was held with their mother, who was also Mark's first wife, on 17th February 2017. This was followed up with a further meeting with her and one of the children on 11th April 2017. Throughout the process there has been additional dialogue by email, text and telephone with the family of Mark.

1.7.10 Both the Chair and Report Writer would like to thank Mark's family for their willingness to engage and the contribution that they have made to this review.

1.7.11 A number of attempts were made to engage with Stephanie's family through the family's single point of contact. This included telephone calls and a letter outlining the review accompanied by the Home Office leaflet for friends and families. Throughout the review process they declined to engage. The Review Panel respects their position and has kept them up to date with the progress of the review.

1.7.12 Mark's family suggested a close friend (and his partner) whom they felt would be able to provide valuable contribution to the review. Despite a number of attempts to make contact with this person, we have not been able to do so.

1.7.13 Letters have been sent to the neighbours inviting them to contribute to the review. One of the neighbours has met with the report author and his contribution has been reflected within the review.

1.7.14 Through the police, an approach was made to the person with whom Stephanie was thought to have a fledgling relationship. He declined to be involved and this position has been respected by the review.

1.7.15 The review's active inquiries concluded in July 2017. The report was completed in August 2017 with a final panel meeting on 24th August 2017.

1.8 Contributors to the review

1.8.1 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.

1.8.2 All Panel meetings included 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, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.8.3 However, it must be noted that whilst a person or body can be directed to participate, the Chair and the DHR 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.

1.8.4 The following agencies contributed to the Review:

- Borough Council of King's Lynn and West Norfolk
- GP surgery for Mark
- GP surgery for Stephanie
- Leeway Domestic Violence and Abuse Services
- MAPPA Co-ordinator
- National Probation Service
- NHS England Midlands and East (East)
- Norfolk and Waveney Clinical Commissioning Groups
- Norfolk Constabulary
- Norfolk County Council
- Norfolk Safeguarding Adults Board
- Office of Police and Crime Commissioner
- Ormiston Families
- Queen Elizabeth Hospital, King's Lynn

1.8.5 The following individuals contributed to the review:

- Mark's children – two meetings with Chair and Report Author
- Ex-wife of Mark – two meetings with Chair and Report Author
- A neighbour – one meeting with Report Author

1.8.6 The Chair considered carefully whether a meeting between the perpetrator's family and the Panel was appropriate given all the circumstances of the case. Given the grief that all of the children were clearly and understandably experiencing at the time when they initially engaged with the review and the confidential relationship that developed between the Chair, Overview Report Author and the children, the Panel took the view that the Chair would represent the Panel and maintain the relationship with the family.

1.8.7 The following agencies declined to assist the review:

- Solicitor who acted on behalf of Mark's first wife at her time of divorce from Mark

1.9 The Review Panel

1.9.1 The members of the DHR Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Nicky Hampson	Service Development Manager, Positive Pathways	Ormiston Families
Margaret Hill	Community Services Manager	Leeway Domestic Violence and Abuse Services
	Nurse Practitioner[2]	Stephanie's GP surgery
Gareth Jackson	Senior Probation Officer	National Probation Service
Dawn Jessett	Community Safety Assistant (DHR Administrator)	Norfolk County Council
Penny Levett	Safeguarding Practitioner	Norfolk and Waveney Clinical Commissioning Groups
Andy Nederpel	Anti-Social Behaviour Manager	Borough Council of King's Lynn and West Norfolk
Val Newton	Deputy Director of Nursing	Queen Elizabeth Hospital
Jane Ross	Patient Experience and Quality Lead	NHS England Midlands and East (East)

[2] Name redacted to protect the name of the victim

Jon Shalom	CCSP Business Lead	Norfolk County Council
Julie Wvendth	Detective Superintendent, Safeguarding	Norfolk Constabulary
Walter Lloyd-Smith	Business Lead for Norfolk Safeguarding Adults Board	Norfolk County Council

1.10 Domestic Homicide Review Chair and Overview Report Author

1.10.1 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. Gary has undertaken three Domestic Homicide Reviews as Overview Report Author or combined Overview Report Author/chair (with five more currently in progress).

1.10.2 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 Healthchecks 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.

1.10.3 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[3]

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

1.10.4 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)
- Attended training on the statutory guidance update in 2016
- Undertaken Home Office approved training in April/May 2017

1.11 Parallel Reviews

1.11.1 The Coronial process relating to Mark's death remains open. At the time of this review there are no other reviews being undertaken.

1.12 Equality and Diversity

1.12.1 Throughout the review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.12.2 Discussions with the perpetrator's family, and friends of both the victim and the perpetrator, reassured the panel that none of these were an issue in this case.

Section Two – The Facts

2.1 Introduction

2.1.1 Both Mark and Stephanie were white British with family ties in Norfolk. They were married in June 2005 after having been together for a couple of years. Stephanie had one child, from a previous relationship. Mark had children from his first marriage and a number of grandchildren.

2.1.2 For 10 years prior to their deaths in July 2016 neither Mark nor Stephanie had any recent contact with the police.

2.1.3 In the weeks prior to their deaths Stephanie and Mark were known to be having problems in their relationship, this was substantiated by texts sent and received in the hours before the incident. On the day of the incident, Mark was known to be very upset and he and Stephanie attended his GP for an appointment at 17.20 hrs. Stephanie did not go into the consultation with him. They returned home where they stayed for the rest of the evening.

2.1.4 On the day of the incident Mark shot Stephanie in the lounge of their marital home and then, in the garden at the front of the house, Mark shot himself.

2.1.5 At the time of the incident, Mark held a shotgun and firearm certificate.

2.1.6 A full chronology of events and a summary of information known by family, friends and agencies will follow within this report.

2.2 Chronology

2.2.1 Background Information

2.2.2 Stephanie was born in Norfolk and at the time of her death was 48 years old. She was an only child. She had one child with her first husband.

2.2.3 Stephanie moved in with Mark in the months following his separation from his first wife, and they were married in June 2005.

2.2.4 Mark was born in a village in Norfolk and at the time of his death was 47 years old. He was married to his first wife between 1992 and 2003. They had a number of children and grandchildren.

2.2.5 Whilst the decision by Stephanie's family not to engage in the review is understood and respected, it has meant that this review could have the capacity to become unbalanced. Cognisant of this fact, the Panel has made all attempts to provide a balanced report.

2.2.6 From talking to his children, we were able to build a picture of Mark's family background. His father died in the early 1990s and not long after this his brother committed suicide. Alcohol then became a big issue for Mark. We were told that he would drink alcohol

excessively for a number of weeks and then just stop. He would then begin to drink again. Everyone we spoke to said that Mark never used drugs at all. When Mark was drinking he could become involved in violent altercations. Enquiries undertaken by Norfolk Constabulary in relation to Mark's application for a shotgun licence support the view that Mark did regularly frequent public houses but it should be noted that he has not been convicted of any offences whilst under the influence of alcohol.

2.2.7 In 2002 the financial position of Mark and his first wife improved substantially. At this time, he began to drink more and more. He did not need to work and so his days lacked structure and he would drink all day long. This improved financial position had an impact upon the whole family – specifically their marriage.

2.2.8 Mark was described by his family as an emotional man who would show his feelings easily – it was not unusual for him to cry.

2.2.9 Mark's children reported that there had been significant domestic abuse by Mark towards their mother. This abuse was witnessed by the oldest child only. The ongoing abuse was confirmed by Mark's first wife who disclosed a number of incidents. The first specific incident that was mentioned by her was that Mark pushed her down the stairs while she was pregnant. She reported physical abuse in that he had, on occasions, held her round her throat and, one time, he held a shotgun to her head. She also reported emotional abuse. For example, Mark would go out in his car when he had been drinking and then ring her to say that he was going to kill himself and she was then forced to go out and look for him. To avoid these situations, she would hide the car keys under her son's pillow and this caused arguments between her and Mark.

2.2.10 His first wife believed, at the time, that she was protecting the children from witnessing the domestic abuse, although we know from what one of the children has told us that she had not been successful. When she realised that she was no longer able to do this she made plans to leave Mark. The improved financial situation made it possible for her to leave Mark taking the children with her.

2.2.11 The domestic abuse remained fairly well hidden within the marriage and she remembers that whenever she did try to tell anyone about it they did not believe her as 'Mark was such a good man'.

2.2.12 After they had separated, Mark believed that his wife was having a relationship with someone else and he would sit outside her house in his car and find excuses to visit her, such as delivering post that was obviously junk mail.

2.2.13 When she left Mark he fought her for custody of the children and they stayed, initially, with him every weekend and every Wednesday but this reduced as the children grew older and wanted to do other things at weekends. There was intermittent contact between the children and Mark in the time leading up to his death. One child appears to have been in the most regular contact with Mark and Stephanie and said that at the time his dad was not drinking. This is not a view corroborated the other children who had seen Mark drunk, or by his first wife who had seen Mark buying alcohol in the local shop.

2.2.14 Mark had held a shotgun licence since 1985, aside from a two-year period between 2003 and 2005 when his marriage had been ending.

2.2.15 In 2002 and 2003, during the breakdown of their marriage, the police have reports about Mark's behaviour towards his estranged wife.

2.2.16 The first of these was on 9th May 2003 when she reported behaviour that included threats of violence towards her and her family. She did not want the police to take any action against Mark. She said that her solicitor had advised her to do so as part of the divorce process. She was later visited by officers offering support who left her with leaflets about domestic abuse and the support available. She declined to take up the offer of support at this time. At this time Mark voluntarily relinquished his shotguns (see detailed chronology in paragraph 2.3).

2.2.17 A further two reports were made by her. On 11th June 2003, she reported that Mark had attended her address and was drunk and 1st July 2003 she reported to the police that there had been more issues with Mark including a threat by him towards her new partner.

2.2.18 In 2003 Mark received a police caution for possessing an offensive weapon when he was at an address to which the police were called following reports of a disturbance. This was not a domestic matter but an unrelated public order offence.

2.2.19 In March 2004 a burglary occurred at the home of Mark and Stephanie. A large quantity of jewellery was stolen. As will be explored later, the inside of the home was covered by CCTV and it is thought that this had been installed as a result of the burglary.

2.2.20 Following this burglary Stephanie reported a number of incidents of harassment towards her and Mark. These are not related to anyone connected with this case.

2.2.21 On 27th April 2004 his first wife reported further threats to her and her new partner when he threatened to 'blow her head off'. The police issued Mark with a harassment warning.

2.2.22 In December 2005, Mark reapplied for his shotgun certificate and this was granted.

2.2.23 It is noteworthy that from the point of their marriage in June 2005 the police have no further contact with Mark or Stephanie until the night of their deaths other than the renewal of the shotgun licences.

2.3 Detailed Chronology of Shotgun Certificate

2.3.1 As the presence of a shotgun certificate has been a key question for both the Panel and Mark's family, the chronology of this is set out below:

16th December 1985	Mark first granted a shotgun certificate
9th May 2003	Ex-wife reported to police that she had been threatened by Mark. She stated that he had threatened her with violence and, in the past had threatened to shoot her. She did not wish any action to be taken or her husband to be spoken to. The Firearms Licensing Team were made aware of the reports as is practice with all individuals with firearms licences.
12th May 2003	As a result of this report, the Firearms Enquiry Officer visited Mark at home and took possession of the shotguns and certificate as a precaution as he was going through a difficult divorce. At this time, there was a loose agreement that this would be for 'a couple of years'.
12th August 2003	Mark was arrested on suspicion of possessing an offensive weapon after he had brandished a baseball bat in the presence of police officers. When interviewed Mark admitted the offence and was given a Police Caution. As Mark was still showing as a firearms certificate holder, despite not having the weapons or the certificate, a report was sent to the Firearms Licensing Team. Again, Mark was visited at home and on this occasion the surrender of his certificate and firearms were formalised and his licence was cancelled.
27th April 2004	His ex-wife reported to police that Mark had made further threats to her and her new partner when he threatened to 'blow her head off'. The police issued Mark with a harassment warning.
28th December 2005	Mark reapplied for his shotgun certificate. As part of this application he disclosed that he had suffered from depression for approximately 3 years following his divorce. The GP's report suggested he had experienced mild depression and was medicated for only two months. A report was prepared in which the officer stated that the reason for having previously requested the surrender of the certificate had now passed. He was, according to his report, aware of the Police Caution but did not feel that this incident was serious enough to warrant refusing the application. The report also recorded that Mark appeared to spend a lot of time in public houses drinking alcohol but he had not come to the police's attention for his behaviour while drunk. The threats to his ex-wife in April 2004 do not appear to have formed part of this assessment and this is explored later in the report.

December 2005	At this point Mark's GP received a form from the police stating that Mark had applied for a shotgun certificate. The GP responded to the police by telling them that Mark had been seen in 2003 when he had been prescribed anti-depressants but Mark had not attended follow up appointments so received no further prescriptions.
27th January 2006	Shotgun certificate was granted by Firearms Licensing Officer after a home visit. The certificate stipulated that the shotguns should be kept away from the home address and advised him that a recurrence of the behaviour that had led to the police caution may result in the revocation of the Licence. This was as a result of threats, not connected to this case, made towards Mark.
2007	Mark applied for a firearm certificate so that he could possess two rifles for vermin and fox control over land where he had shooting rights. As he had not come to adverse attention since 2003 the application was granted. The firearms certificate accepted that the weapons would be kept as his home address.
September 2012	Both certificates were renewed as no issues were identified. This process included a home visit and an enquiry to his GP. There was, at this time, no requirement for the guns to be kept away from the family home. Mark's GP received a form stating that he had applied for a shotgun certificate (it is assumed that this was part of the regular checks). As he had not seen Mark recently, he did not respond which is in line with the requirements of the form
	Nothing further had come to the attention of the Firearms Licensing Unit since the renewal of the certificates in 2012
4th October 2017	The firearm and shotgun licence were due to expire on this date

2.3.2 In order to assist in understanding the timeline for this chronology, a different format has been used in Appendix One which presents the timeline to scale.

2.3.3 The issue of the shotgun certificate will be explored further in paragraph 3.3.30.

2.4 Detailed Chronology from December 2015 to 12th July 2016

2.4.1 In December 2015 Stephanie became friends with Witness A. Witness A had gone through a marriage breakup and Stephanie was unhappy in her marriage.

2.4.2 From statements made to the police we are able to say that it also appears that, a few weeks before her death, Stephanie confided to close family that she was having relationship problems with Mark.

2.4.3 In June 2016 Stephanie and Mark went on holiday. When she came back Stephanie told Witness A that she was really unhappy as Mark had been drunk most of the time. Her contact with Witness A became more frequent.

2.4.4 In early July 2016, a close friend for more than 15 years was on holiday when he received a phone call from Mark who told him that Stephanie had said that she did not love him anymore.

2.4.5 Stephanie's friendship with Witness A developed with her visiting for the first time in early July 2016. She then visited him the following Saturday and Stephanie stayed at her mother's over this weekend.

2.4.6 Through their investigation, police also learned that Mark was at the home of his mother a few days later and at approximately 8pm a friend of his mother arrived at the house. Mark was upset and his mum asked him to talk to her friend which he did. She reported that Mark was very emotional and was crying at some points. He told her that Stephanie had changed recently and showed her a video on his phone which appeared to show Stephanie drunk. This was very unusual as Stephanie did not drink. Mark told her that he suspected that Stephanie was having an affair and she had asked him for 'more space' and Mark said, 'I am giving her all the space she wants, she can do what she likes'. Stephanie had told Mark that 'she loved him but wasn't in love with him'. Mark did not understand what this meant and that he 'worshipped the ground that she walked on'. He told her that if Stephanie left him he would lose everything.

2.4.7 At 06.15 hrs, on the day of the incident, Mark rang a friend whom he worked with, and told her that he was depressed and that he thought that Stephanie was having a relationship with someone else. She said that they would talk more when he arrived at work. However, on arrival at work, he was in an extremely emotional state. He confided that Stephanie had told him that she loved him but not in a way a wife should. Mark was very tearful and upset and said he could not survive without her. As he was not in a fit state to work that day she said he should go home and see his doctor.

2.4.8 His close friend received another call from Mark asking him to pop round when he arrived back from holiday.

2.4.9 Stephanie saw Witness A at work and told him that Mark was at home as he was too upset to work.

2.4.10 At 12.00 hrs Mark went to see a neighbour, whom he had known for a considerable time. He was extremely upset and started to cry. He disclosed that he suspected that Stephanie was seeing someone else. She suggested that they try marriage guidance counselling and he told her that he was due to see his GP. Later that same afternoon, Mark had a conversation with this neighbour's husband when he visited Mark at his home after being told by his wife that Mark was very upset. Mark was still in an emotional state and again said that he thought that Stephanie was seeing someone else.

2.4.11 At 14.00 hrs the close friend went to see Mark. He was accompanied by his wife. Mark told them that he had found clothing in the washing and, as a result of which, he was convinced that Stephanie was having an affair. Mark stated that he had been looking at Stephanie's emails and that he had found some from match.com, a dating website. Mark was very upset and we know from a text sent by this lady to Stephanie later in the day that he broke down and he was physically sick. He was concerned about money if they did split up. Mark was due to attend his GP with Stephanie when she got home from work. They left the house at 15.20 hrs.

2.4.12 Stephanie arrived home from work at approximately 15.54 hrs. The following sequence of events is taken from the CCTV that was in the house, as documented by the police (the relevant still image captures have been made available to the Chair and Overview Report Author). It should be noted that the CCTV does not have any sound and therefore the conversations cannot be heard.

2.4.13 At 16.00 hrs Mark and Stephanie are seen in the kitchen and appear to be in discussion and Stephanie keeps putting her head in her hands. One minute later, Stephanie suddenly gets up and begins to walk away from Mark and he catches her right arm as if to stop her walking away. Stephanie appears to wipe her eyes as if crying, Mark walks round in front of her and hugs. Although Stephanie resists the hug at first, she then puts her right arm around Mark. Stephanie sits back down facing Mark who remains standing and both appear to be upset. Mark is seen moving back and forth across the kitchen and both are using their arms in gesture whilst in discussion. Mark is then seen to get up off the stool and move towards Stephanie who is still sitting. He stands behind her and uses both arms to embrace her. Stephanie gets up off the stool and goes to get something from behind the kitchen door. Mark also stands up and Stephanie and Mark are seen to stand together hugging briefly. (15 minutes have now elapsed).

2.4.14 At 17.06 hrs Stephanie and Mark leave the premises.

2.4.15 At 17.29 hrs Mark went to see his GP. Stephanie did not accompany him into the consultation. Mark was very tearful and said he was going through a marriage breakdown and his wife was leaving him. He said that things had come to a head this weekend and he suspected that she was having an affair. He asked for the 'same tablets as he had had before' and was prescribed Citalopram for depression. The GP asked a series of questions relating to the risk of self-harm and suicide and reported that Mark demonstrated forward planning. He said, for example, that if Stephanie left him he would go to his mother's house for a while. The GP said that he was as certain as he could be that Mark had no plans to harm himself when he looked him the eye and said, 'I have lovely grandchildren'. The appointment ended at 17.48 hrs.

2.4.16 Mark and Stephanie arrived home at approximately 18.12 hrs.

2.4.17 The CCTV inside the house has been reviewed by the Chair and Report Author and it is clear from these images that between 18.19 and 18.38 hrs Mark took the shotgun and placed it under the bed, going back shortly afterwards to load the ammunition.

2.4.18 At 18.00 hrs the wife of the close friend sent a text to Mark asking how he got on at the doctors. He told her that he had been given depression tablets. After this she exchanged a series of texts with Stephanie and during this exchange Stephanie said that she wanted to be on her own.

2.4.19 From 18.12 hrs Stephanie began a text conversation with the lady mentioned in previous paragraph which continued throughout the evening. During this conversation Stephanie disclosed her relationship with a third party but said she did not know where the relationship would end up but that she did not love Mark in the way that she ought to and that their relationship was ending.

2.4.20 At about 18.30 hrs a local resident was walking past the rear of the address when he saw Stephanie, whom he knew, come out into the rear garden and sit with her head in her hands on the garden bench. Stephanie did not acknowledge him as she normally would.

2.4.21 At around 20.00 hrs Stephanie sent a text to Witness A saying that she had told her husband that she had been at his house on Saturday to talk. She said that her husband was sitting beside her whilst she was texting.

2.4.22 At 20.49 hrs Mark telephoned his close friend's wife and told her that he felt better as Stephanie had admitted what she had done. He told her that Stephanie had met up with this person over the weekend rather than seeing a friend and that nothing had happened.

2.4.23 Around 21.00 hrs Witness A received a further text from Stephanie saying she had told Mark that they had slept together on Saturday. Witness A did not reply as he had no way of knowing who had written the text. He received no further texts from Stephanie.

2.4.24 One of Mark's children had been communicating with him by text messages over the weekend. He disclosed that he had been having relationship problems with Stephanie whom he suspected of having an affair. During the evening (Monday) he sent her a text saying that she had admitted seeing someone else and that she had had sex with him.

2.4.25 Between 21.00 and 22.00 hrs Mark tried to speak to this child on the phone a number of times but they had fallen asleep.

2.4.26 At 21.14 hrs Mark's friend from work received a text from him saying 'She has just told me she is seeing …… she said she didn't go to work on Saturday she went to his and Saturday night she went also.'

2.4.27 At 21.20 hrs she received a telephone call from Mark. He told her that he felt much better now that he knew the truth. While they were on the phone, she heard Mark say 'Come on, don't cry, we can sort this out'. At this point she advised Mark that he should be sorting things out with Stephanie rather than talking to her. She urged Mark not to do anything stupid and asked him to promise her he would see her tomorrow. Mark stated that he was right as rain now. The call was then ended.

2.4.28 At 21.36 hrs Mark rang his close friend's wife and told her that Stephanie had just admitted having sex with …… She continued to have text conversations with Stephanie and during these conversations Stephanie told her that she did not love Mark anymore. The final text sent to her was at 23.17 hrs.

2.4.29 At approximately 22.00 hrs Mark telephoned his mum. During this conversation, he told her that he had some antidepressants from the doctor which he had been advised to start taking the next morning. He told her that Stephanie had said she was having an affair and had had sex with him on Saturday. His mum said that he seemed calm and went on to say that they were going to stay together until they had cleared some of their debt. He kept saying during the conversation 'Remember, I will always love you mum'.

2.4.30 At 23.43 hrs Mark sent a final text to one of his children. It said, 'look after yourself and my grandchildren and my mum love you always dad xxxxxxxxxxxxxxxxxxxxxxxxxxx'. This text message was not received.

2.4.31 At 23.49 hrs Mark is seen on CCTV looking very upset with his head in his hands and he remains like this until 23.55 hrs. At 23.57 hrs Stephanie is clearly upset sitting with her head in her hands. A few minutes later Mark fatally shoots Stephanie and leaves the property carrying the shotgun.

2.4.32 A neighbour had gone to bed at 10pm in her room at the front of the property. She was awoken by Mark shouting 'I have just shot Steph'. She looked out of her bedroom window and could see that the front door was open wide and the hall lights were on. She told her husband and daughter what had happened and they all went outside where they met their other neighbours.

2.4.33 One of the neighbours went and looked into the front garden and saw Mark lying on the ground not far from the fence and there was a shotgun next to him. An ambulance was called. One of the neighbours continued to speak to the operator and went to check on Mark. Mark was found with extensive head injuries and was no longer alive.

Section Three – Overview and Analysis

3.1 Summary of information known to agencies, family and friends

3.1.1 Both Mark and Stephanie had limited contact with statutory agencies, particularly in the ten years since their marriage. No contact with any voluntary agencies by Mark and Stephanie has been identified during this Review.

3.2 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 the agency involvement.

3.2.1 General Practitioner services provided to Mark and Stephanie

3.2.1.1 Stephanie's GP engaged with the review but there was a significant delay in receiving this information. This delay was in part due to confusion over payment for engagement in the review. He advised that, on no occasion, had Stephanie disclosed any domestic abuse on attendance at the surgery. In addition, scrutiny of her medical records does not reveal any unexplained injuries which might have prompted more probing questions by the GP. The records had not recorded if Stephanie attended alone for the consultations.

Recommendation – National

It is recommended that, despite the strengthening of the latest statutory guidance more work needs to be done to ensure the co-operation of GPs with Domestic Homicide Reviews. As the problem in this case appears to have been, in part, the payment to be made for engagement, it is recommended that either an agreement is reached about payment for these reviews or it is included in the existing contracts.

3.2.1.2 Although Mark had been known to his GP for a number of years he was not a regular visitor to the surgery.

3.2.1.3 The GP was able to tell us that in November 2002, Mark had visited his GP reporting that he was struggling with insomnia and stress.

3.2.1.4 Mark visited again in March 2003 at the time when his first marriage was breaking down. He was tearful and told the GP that he was not sleeping. He was prescribed a course of anti-depressants and attended a follow-up appointment some two weeks later. As he was not feeling better it was agreed that he would be reviewed again in one month but Mark did not attend this follow-up appointment.

3.2.1.5 Other than infrequent routine appointments for one-off issues Mark had no more contact with his GP until the night of the incident. The consultation was with Mark only, Stephanie was not present. He told the GP that he was again going through a marriage breakdown and he was having difficulty sleeping. He was very tearful and asked for the 'tablets he had had before'. The GP talked to Mark about how he was feeling and probed as to whether Mark had any thoughts of self-harm or suicide. Mark demonstrated forward planning in that he talked about what he planned to do if Stephanie left him. The GP said that, as far as he could be, he was satisfied that there were no immediate plans for self-harm or suicide. He says that Mark looked him in the eye and said 'Mr ……., I have a number of lovely grandchildren. Why would I do something?'

3.2.1.6 Mark's GP did say that, with hindsight, he wonders if he should have asked Mark if he had any thoughts of harming another person. The GP confirmed that he, and his colleagues, would now extend their question to patients to ask, 'have you any thoughts of harming yourself or others?' But given the conversation about thoughts of harming himself, there is nothing to suggest that Mark would have been honest if, in fact, he had made the decision at that point to take the lives of himself and Stephanie.

3.2.1.7 It was clear from the GP that he was fully aware of the procedure that he would have followed for making an emergency referral if he had any concerns about Mark's mental state beyond that with which he presented. He was able to recount a case where a patient came to the last appointment of the day and he was so concerned about her mental state that he stayed in the surgery with her until he was able to get a counsellor to speak to her on the telephone.

3.2.1.8 Interestingly, the GP did not have any record of Mark ever having consulted him about his alcohol use and on the day of the last meeting he said that he was not using drugs or alcohol to a dangerous level.

3.2.1.9 The GP practice at which Mark was a patient has a very comprehensive 'At-Risk Adults Policy' which was introduced in January 2016. This policy clearly recognises domestic violence as one of the social factors that may facilitate abuse and recognises that abuse may take many forms including, for example, physical acts, sexual acts, psychological and emotional. All the staff at the practice (both clinical and non-clinical) received a two-hour presentation from Leeway in 2016 as part of their ongoing professional development.

The Review concludes that it is difficult to see what more the perpetrator's GP could have reasonably done in this case. He asked questions of the perpetrator in order that he could gauge, based on the answers given, if he was in need of an urgent referral to Mental Health Services and quite reasonably concluded that this was not needed. The Review noted that Norfolk is working to extend the network of DA Champions to universal services in health and education. This would enable GP surgeries to identify staff who can train as their organisation's DA Champion, supporting colleagues to recognise and understand the dynamics of DA, identifying where this may be an issue through sensitive routine enquiry, making referrals to police specialist agencies as appropriate, and providing further guidance and safety planning to their patients.

Recommendation – Professional Curiosity
That the GP practices across the county consider having Domestic Abuse Champions in their surgery.

3.2.2 The Queen Elizabeth Hospital, King's Lynn

3.2.2.1 Stephanie had, according to the records provided to the review, attended the Accident and Emergency Department of the hospital on six occasions between 1996 and 2016. None of these presentations appeared, when scrutinised by hospital staff, to be related to an assault or suspicious injury.

3.2.2.2 During the time between 1996 and 2016, Stephanie had been under the care of a gynaecological surgeon on numerous occasions, a medical consultant and an orthopaedic consultant. She had been admitted to hospital on different occasions with abdominal pain, indigestion, chest pain and back pain.

3.2.2.3 Mark had attended Accident and Emergency on seven occasions since 1996. He had two or three surgical interventions.

3.2.2.4 The Individual Management Review undertaken by the hospital indicates that there were no interactions with the hospital that would have been identified as being directly as a result of domestic abuse (e.g. broken bones) but does not indicate that there were any conversations, particularly with Stephanie, that might have led to a disclosure of domestic abuse. The Review notes the work being undertaken in Norfolk to train Domestic Abuse Champions within a range of settings with a particular focus on health and the fact that the hospital is looking to engage with the programme in all areas not just Accident and Emergency and maternity.

Recommendation – Professional Curiosity
That the hospitals across the county consider having Domestic Abuse Champions in all their departments.

3.2.3 Borough Council of King's Lynn and West Norfolk

3.2.3.1 Mark and Stephanie had limited contact with the local authority.

3.2.3.2 There had been no reports by or about Mark and Stephanie recorded by the Anti-Social Behaviour Team.

3.2.3.3 Mark and Stephanie are known to have owned dogs and on three occasions a complaint was made to the Council about the noise from the dogs barking. These complaints related to two separate incidents (with two complaints about the same incident).

12th September 2007 – It was reported that the dogs would bark when someone passed along the riverbank (behind the house) and that this would begin from 6am. Following receipt of a standard letter, Stephanie had phoned the Council to discuss the complaint. She felt that she knew who was responsible for the complaint as they did not get on with one of their neighbours. The complaint was closed on 22nd September 2008 with no further action.
13th September 2007 – duplicate complaint recorded as above

14th June 2011 – New complaint about barking dogs. The standard procedure was followed and following investigation the complaint was closed with no further action.

The Review concludes that the Council investigated the complaints received and as there was no further action taken the contact was limited.

3.2.4 Norfolk Constabulary

3.2.4.1 Mark and Stephanie had no contact with the police following their marriage in June 2005. There had been no reported incidents of threats, violence or abuse recorded by the police and no calls for service to their home address.

3.2.4.2 Mark had held a shotgun certificate since 1985, aside from a period of two years between 2003 and 2005 when he initially voluntarily surrendered them before the certificate was formally revoked while he was going through his divorce. This issue is covered in detail later within this report.

3.2.4.3 Mark's main contact with the police has been in connection with his application for shotgun and firearms certificates. However, in 2002 and 2003, during his divorce, Mark came to the attention of the police for threats to his ex-wife.

3.2.4.4 The Panel has reviewed those previous reports by his ex-wife to the police. Reports were made on two separate occasions after they had separated. The reports amounted to verbal intimidation by Mark including threatening to kill her with a shotgun. On both occasions, the victim did not want the police to take any further action. However, the police do appear to have acted appropriately on both occasions with both incidents being recorded, references made to Victim Support and notification to the Firearms Officer of the incidents. The Panel has considered carefully the relevance of these incidents given the passage of time and feel that they do tend to show the perpetrator was prepared to use threats and intimidation at a time of great stress such as the stress he would have felt at the time of this incident. However, detailed scrutiny of these two incidents is not necessary for the purposes of this report.

3.2.4.5 In August 2003 Mark received a police caution for possessing an offensive weapon at an incident at a family member's address.

3.2.4.6 In 2004 Mark reported a burglary during which a large amount of jewellery and cash were stolen. These goods belonged to a member of Mark's family and led to a deterioration in that family relationship. After this incident, Stephanie reported a number of incidents of harassment towards her and Mark.

Whilst the Review concludes that the police appear to have acted in a considered, proportionate and appropriate way in relation to these incidents when each is considered in isolation, it will explore elsewhere whether the domestic abuse towards Mark's first wife might have been identified and how the granting of the shotgun certificate might have impacted the case.

3.2.5 Neighbour to Mark and Stephanie

3.2.5.1 The Review is grateful to the neighbour for their contribution which has added another dimension to the events of the night.

3.2.5.2 Mark and Stephanie were described as a very loving couple who had just come back from holiday and were already planning their next holiday, which they planned to take alone rather than with another family as on this occasion. The neighbour described them as always doing everything together – going to the pub, shopping – the only time they were apart was when they were at work. Mark was described as doting on Stephanie.

3.2.5.3 The neighbour described Mark as a fiery character who would respond if he was wound up. The neighbour was surprised at Mark's actions as he felt he would have been far more likely, on discovering Stephanie was having an affair, to find out who the person was and go and deal with him directly.

3.2.5.4 Interestingly, the neighbour (who did socialise with Mark and Stephanie) said they he had never seen Mark drunk and he was surprised to discover that Mark was suffering from depression.

3.2.5.5 As part of the conversation with the neighbour he talked about the time after the incident and his recollection now of that time is that there was no support for him and the other neighbours or advice on the agencies that could offer support.

Whilst it is acknowledged that the police would have been very involved with the investigation into the incident, consideration could be given by Norfolk Constabulary to providing those who have witnessed such an incident with the details of Victim Support and/or other agencies that could offer support.

3.3 Other issues considered

3.3.1 There are a number of key questions which are asked as part of a Domestic Homicide Review, namely, could the homicide have been predicted? Or prevented? This section will consider these questions drawing on the information that is available to the review and research undertaken into domestic homicides.

3.3.2 As has already been discussed within this review we have available to us information from Mark's ex-wife and child about the relationship between Mark and his ex-wife but we have a blank page when it comes to understanding the relationship between Mark and Stephanie, which means that there will, inevitably, be some questions that are left unanswered but some general observations can be made from the small pieces we have and drawing on research that is available to us.

3.3.3 From Witness A's statement we know that Stephanie had told him that she had not been happy in her marriage since at least Christmas 2015. She told him that Mark got 'pissed' every night, that he was controlling and possessive, especially when he had been drinking.

3.3.4 We know from this witness statement that he believed that Mark was sitting next to Stephanie while she was texting and was known to check her emails.

3.3.5 We know that Stephanie's car belonged to Mark and in the text conversation with her close friend they discussed whether he would let her keep the car.

3.3.6 Her close friend told Stephanie, in her text, that Mark had said that he could not live on his own and that her husband was concerned about him going like he did when his first marriage ended. She said that she thought he would go downhill very quickly.

3.3.7 Mark and Stephanie's neighbour described them as a devoted couple who did everything together, that Mark would even go with Stephanie if she went to the supermarket. We can take this comment at face value, in the way in which it was meant – that they were a devoted couple who wanted to spend all of their time together. Alternatively, we might take the view that this was evidence of Mark's control of Stephanie that she was not able to even go to the supermarket alone.

3.3.8 Despite the glimpses set out above into Mark and Stephanie's relationship we cannot be 100% certain whether or not there was any domestic abuse by Mark on Stephanie but the 'highest risk behaviour for predicting future homicide is a prior history of domestic abuse and domestic abusers are serial abusers. Contrary to the popular belief that they are responding to the victim's provocative behaviour and losing control, the truth is that they are serial abusers who are *exerting* control'.[4] Therefore we can conclude, without being able to test this out, that it is more likely than not that Mark was abusive towards Stephanie.

3.3.9 There are other pieces of information that are known to the review that raise questions about Mark and his control in his relationships and in his home. The house was covered, inside the property, with CCTV which we understand to have been installed following a burglary at the property in 2004 when a substantial amount of cash and jewellery had been stolen. Given that the burglary had been more than a decade earlier, and valuable goods were not kept in the property in the same way, it seems unusual that the house would have so much internal CCTV that continued to record and does this raise questions about Mark's need for control?

3.3.10 What is clear from the history provided by the family is that there was a side to Mark that was never seen or identified by those in the statutory agencies who met him.

3.3.11 This leads us to question whether Stephanie's death could have been predicted. The research that is available to us sets out a list of high-risk characteristics used to predict dangerousness or risk for homicide. The evidence that we have leads us to suggest that of the fourteen high-risk characteristics, we have evidence to support more than half of these in the case of Mark, in relation to his first wife:

[4] Domestic abuse, Homicide and Gender, Jane Monckton-Smith and Amanda Williams with Frank Mullane, Palgrave Macmillan, 2014

Previous domestic abuse
Both his first wife and child independently reported domestic abuse over many years by Mark towards her. While we do not have a detailed picture of this we do know that there were some serious threats to harm her such as holding her by the throat and holding a shotgun to her head.

Separation or the threat of separation
It is well documented from the texts sent by Mark, conversations he had with others and the visit to the doctor that Mark believed Stephanie was intending to leave him.

Threats to use, or use of, a weapon
We know that Mark had threatened, more than once, to harm his first wife with a weapon. Mark also received a police caution for possessing an offensive weapon when he was at a location to which the police were called following a disturbance.

Threats to commit suicide
His first wife disclosed that Mark would go out in the car when he had been drinking and then he would telephone her and tell her that he was going to kill himself. She would then go out in the car and look for him. Obviously, only Mark knows whether he seriously considered suicide or whether this was part of his control of her.

Violence
As discussed previously, one of his children witnessed domestic violence towards their mother. Although she has not discussed in detail her years with Mark, it is clear from all reports that this continued over a long period of time.

Pregnancy (especially violence)
His first wife reported that Mark pushed her down the stairs whilst she was pregnant.

Stalking or harassment
In the weeks/months after their separation, Mark would go to her new address and sit outside in the car for long periods of time as well as, in her own words, making excuses to go around with post that was obviously junk mail. It is noted that this behaviour continued after Stephanie had moved in with Mark and she would, on occasions, be with him when this occurred.

Arguments over child contact
His first wife reported that there had been some animosity over the custody of the children when they divorced.

3.3.12 When we look at this evidence, it would be easy to say that this incident could have been predicted but we must remember that Stephanie was not known, during the 10 years of her marriage to any of the agencies that might have reasonably been expected to identify the risk. Taking a step back in history, his first wife says that she never reported the abuse that she had been suffering. Only at the time of her divorce, on the advice of her solicitor, did she report to the police that he had threatened to kill her with a shotgun. At that time, she was contacted by a support worker (although she cannot remember the exact details of the agency that this person was from and what was offered) and did not take up any support.

3.3.13 This leads us to ask whether enough is done in Norfolk to ensure that people are aware of the services that are available to them and, more importantly, what domestic abuse is and also that it is not acceptable. We must remember that it was from the early 1990s that Mark's first wife was experiencing domestic abuse and it is recognised that this should be considered in light of the very different context of the time. We do know that she did try, on occasions, to tell members of her family about what was happening but they did not believe her and this, arguably, reflects the views about domestic abuse at that time.

3.3.14 His first wife had made the break from Mark and we can only speculate about whether she would have taken up support had she still been living with Mark. What we can say is that she was a protective factor for her children and, at the point when she was concerned for the effect of the abuse on them (having believed that they did not see it earlier) she left the family home.

3.3.15 Again we do not know why Stephanie, if she were experiencing domestic abuse, did not seek help.

3.3.16 The work, highlighted below, that is planned to raise awareness among the wider community such as hairdressers, dentists and Soroptomists will contribute to an increased opportunity for women such as Mark's wives to hear about support services that are available.

3.3.17 **Norfolk's approach to tackling domestic abuse**

Responding to earlier DHRs, Norfolk County Community Safety Partnership undertook a multi-agency consultation and review of services in 2014 in order to proactively change how agencies respond to domestic abuse. This led to the implementation of the county-wide Change Programme which seeks to encourage early disclosure through enhancing the knowledge of front-line staff and wider community capability.

3.3.18 A key part of this Change Programme was the establishment of a wide-ranging network of domestic abuse 'champions' who are recruited and trained by Domestic Abuse Change Co-ordinators; three posts across the county. The main focus of their role is service development and supporting front-line professionals, rather than being a direct link to families on a regular basis. All Domestic Abuse Champions undergo two days' training in which they explore additional barriers for vulnerable or minority groups and consider honour based abuse, forced marriage and female genital mutilation.

3.3.19 Since September 2015 the Domestic Abuse Coordinators have:

- Trained 500 champions across 259 different services and teams
- Provided 200 professional consultations to workers attached to Early Help Hubs
- Provided general advice and guidance on a daily basis
- Delivered awareness raising sessions to 785 professionals
- Undertaken direct work with vulnerable and minority groups via Operation Limelight and some direct targeting of agencies involved with supporting minority groups
- Created a new group of webpages with the Norfolk County Council website which contains information, guidance and resources – it is of note that these pages allow users to exit the page quickly without leaving any trace in their browsing history and

that a search on 'domestic abuse support in Norfolk' takes the user straight to this page
- Produced a monthly newsletter

3.3.20 A progress report, produced in December 2016, identified a number of key areas for development of the role of Domestic Abuse Change Co-ordinators including:
- Continuing the Champions' training with more focus on specific targeted groups
- Moving the balance towards providing a consultancy service for practitioners in the Early Help Hubs
- Targeting of healthcare professionals – recent Domestic Homicide Reviews have highlighted that GPs and nurses are often the first point of contact for victims of domestic abuse because they will often present with a mental or physical condition that is as a result of domestic abuse. However, it is not always routinely considered by GP practice staff
- Training 150 champions across school nurses, health visitors and related professionals
- Targeting schools and other educational establishments and Adult Services
- Awareness raising in private companies and the wider community

3.3.21 Norfolk has been awarded £300,000 by the Home Office as part of the Violence Against Women and Girls Transformation Programme to extending the network of Domestic Abuse Champions across health and school settings.

3.3.22 Norfolk has historically sought to raise awareness with an annual 'Norfolk Says No' campaign alongside individual agency work. In 2015 market research was commissioned that asked professionals, service users and members of the public to provide feedback to inform a communications strategy for the next two years. As a result of this, it was agreed that a more strategic countywide approach was needed and the Domestic Abuse Change Programme (DACP) was implemented by the Norfolk County Community Safety Partnership. A new campaign - *#I walked away* was launched in June 2016. This campaign, as well as having a clear action plan, has campaign aims, objectives and messages.

3.3.23 Norfolk is able to offer, in West Norfolk, a Domestic Abuse Intervention Programme delivered by Ormiston Families to male perpetrators. Men are accepted onto this 27-week programme after a 1.5 hours assessment. In developing this programme, Norfolk has taken note of the research that shows that referring a perpetrator to a generic anger management programme can increase the risk to the victim as it will teach skills such as negotiation which can then be used manipulatively in an abusive relationship. The programme will also target impulsive behaviour and we know that domestic abuse is not impulsive. The Choosing to Change programme includes non-violent conflict resolution, which is a different skill, considering partners' viewpoints first so they feel safe to openly disclose. Discussions are currently underway around the permanence and breadth of this programme.

The Review is satisfied that agencies within Norfolk have not only taken on the learning from previous Domestic Homicide Reviews but have also made significant financial commitment to improve awareness about domestic abuse around the county. The initiatives summarised above are examples of evidence-based good practice.

3.3.24 If we move to the weekend preceding Stephanie's death we can see that there is evidence that Mark displayed behaviours and feelings that research suggests are part of a domestic homicide followed by suicide[5]. Liem and Roberts (2009) say that it is more common that a domestic homicide followed by suicide will be preceded by depressive illness. We know that Mark visited his GP on the night of the deaths and reported that he needed the anti-depressants that he had been prescribed previously. Whilst Mark told his GP that his depression was caused by the imminent break up of his marriage, we do not know how long he had been feeling like this. From the evidence that is available to us about the events of the preceding days we might form a view that this was a situation that was short lived. We do not know with certainty the state of the marriage in the weeks and months previously or how Mark had been feeling.

3.3.25 What we do know is that Mark and Stephanie had reached a point in their relationship where Stephanie, at least, was considering leaving and research shows that the *biggest trigger* for an abusive man to commit fatal violence is separation or the threat of separation.[6] Men are, the research tells us, threatened by the loss of control and will do anything to regain control.[7] The risk of violence increases after separation or the announcement of an intention to separate. As the CCTV coverage that is available from inside the house does not have sound recording we cannot know exactly what was going on between Mark and Stephanie. We can see that both Stephanie and Mark were upset but we do not know what was said. We do not know whether threats were made by Mark to Stephanie during this evening. We do know that when an acquaintance walked on the footpath behind the house she did not speak to him as she would normally have done but we can only guess why that might have been. From the records of the texts between Stephanie and her close friend during the evening we can see that Stephanie is upset and remorseful about how distressed Mark was about the potential breakup of the marriage. There is a sense, in the texts, of her feeling helpless – that she could not help how she felt. We do not know if Stephanie had any idea of the danger that she was in that evening.

3.3.26 The research shows us that the evidence from men who murder their partners and then take their own lives is a 'far-reaching dependency on the victim and fear of abandonment'.[8] There is strong evidence in this group that a key source of frustration is the perpetrator's inability to live without the victim. It is very clear from the events of the evening, and the preceding days, that Mark was very distressed about the prospect of Stephanie leaving him and one could reasonably conclude that this was the motivation for the action that he took. We cannot be sure what it was that made Mark feel that he could not go on without Stephanie, such as financial reasons or a feeling of not being able to cope without her but what is clear is that, at that time, these outweighed any thoughts of what he was losing.

3.3.27 This conclusion leads us to ask another question and that is whether Mark 'snapped' in a moment or whether the shooting was pre-meditated and planned. Only Mark will know if he began to think about this in the days before but what is clear from the CCTV evidence ~~is~~

[5] Liem and Roberts (2009) quoted in Domestic abuse, Homicide and Gender, Jane Monckton-Smith and Amanda Williams with Frank Mullane, Palgrave Macmillan, 2014

[6] Domestic abuse, Homicide and Gender, Jane Monckton-Smith and Amanda Williams with Frank Mullane, Palgrave Macmillan, 2014

[7] Domestic abuse, Homicide and Gender, Jane Monckton-Smith and Amanda Williams with Frank Mullane, Palgrave Macmillan, 2014

[8] Liem and Roberts (2009) quoted in Domestic abuse, Homicide and Gender, Jane Monckton-Smith and Amanda Williams with Frank Mullane, Palgrave Macmillan, 2014

that Mark was preparing for this act when he and Stephanie returned from the GP. We know, from CCTV evidence, that they returned home at approximately 18.12 hrs and at 18.38 hrs, less than half an hour later, Mark collected the shotgun and placed it under the bed and then went out of the room, returning with the ammunition and loading the shotgun before placing it under the bed. Mark then, as we know, spent the evening not only talking to Stephanie but also sending texts to his family (these texts could be construed as 'goodbye messages' for those close to him) before taking the shotgun from under the bed just after midnight. This evidence clearly suggests that Mark did not 'just snap' but that he had been planning the final actions.

3.3.28 The review believes that, with hindsight and the benefit of research, the events of the fateful evening could be predicted. However, there is no evidence to suggest that any of those who had contact with Mark and Stephanie could have been expected to 'guess' what would happen subsequently.

3.3.29 In simple terms it may be argued that Mark's GP should have done more but we must remember that Mark was a man who had not been to the GP for some considerable time, did not have a history of recurrent or persistent depression and who, when asked, did not say anything that would suggest that he was planning to cause harm.

3.3.30 **Presence of a shotgun in the home**

When we consider if these tragic events could have been prevented, one question which is of particular importance to Mark's family is 'should he have had access to a shotgun?' especially when Mark had, in the past, made threats to kill his first wife.

3.3.31 This section of the report will seek to explain the process for issuing a shotgun and firearms licence and ask whether this procedure was followed robustly and if there are any recommendations that need to be made concerning changes needed both to local policies and national guidance. This must, however, be considered alongside the geographic area in which this review sits. Norfolk is a very rural area where shooting is part of the culture of the area. Mark's GP commented that a large proportion of his patients would have a shotgun certificate. The prevalence of guns in this rural community is not unusual in this setting.

3.3.32 The Home Office is very clear that firearms law and licensing is in place to allow the legitimate possession and of firearms by those judged safe to do so. The overarching consideration is always public safety[9]. The purpose of a firearm certificate procedure is to ensure, in as far as is reasonably possible, that a certificate is issued only to a person who:

- Is found to be a 'fit person' and
- Has demonstrated a 'good reason' to own a firearm

3.3.33 Application is made by means of an application form which requires the applicant to complete:

- Personal details
- Personal health and medical declaration – this will be discussed in more detail later
- Any offences of which the applicant has been convicted

[9] Guide on Firearms Licensing Law, Home Office, April 2016

- Details about the shotgun or firearm including – calibre, type, make and serial number of the weapons to be owned
- Reasons for wishing to own the shotgun/firearm along with details about where they will be used
- Details of security arrangements for the weapons and ammunition

The applicant is then required to sign a personal declaration which includes a statement about data protection and the sharing of information with other agencies. The applicant is also required to provide:

- Four identical photographs
- Details of two referees to support the application who meet the specified requirements

3.3.34 Before the certificate is granted at least one of the referees will be contacted. This might be by telephone, email or home visit depending on the level of risk. The minimum requirement is that the referee is made aware of the application so that they can contact the police with any concerns.

3.3.35 From 1st April 2016, new information sharing processes between GPs and the police were introduced. Upon receipt of an application, if the applicant has declared a relevant medical condition (on a list provided by the Home Office) the police may ask the applicant to obtain and pay for a medical report to assist their consideration of medical suitability. If there is no medical condition declared, there would be no contact with the GP at this stage.

3.3.36 Following the granting of a certificate, the police will contact the GP to ask them to place an encoded reminder on the patient record so that the GP is aware the person is a firearm certificate holder. This indicates that the person holds a shotgun/firearm certificate. This enables the GP to discuss the issue with the patient and, if necessary, inform the police if any concerns about the person's medical fitness arise during the validity of the certificate. The letter also states that the police will inform the GP if the certificate lapses or is revoked or cancelled whereupon the GP can inactivate the firearm code.

3.3.37 In most cases, unless the applicant has declared a medical condition, the GP will not have been contacted during the application process and the letter will normally ask if the GP has concerns about the person's possession of a firearm certificate or if they have suffered a relevant medical condition (over the previous five years) which could affect their suitability to possess a firearm or shotgun certificate. It is worthy of note that the Home Office guidance does not say how soon this letter must be sent – therefore if someone has not declared a medical condition there could be a lapse in time between the certificate being granted and the GP knowing and raising concerns. If the GP does have concerns they should contact the police within 21 days by letter or email. If the GP states that they have concerns but does not provide more detail the police may request, and pay for, a medical report.

3.3.38 The GP should place an encoded reminder on the patient's record when they receive the letter from the police following the grant of the certificate. The encoded reminder allows the GP to consider notifying the police if a person's medical condition gives rise to concern during the validity of the certificate. There is no requirement for the GP to monitor or assess a patient who currently holds a firearm certificate but there is a duty on the doctor to

disclose information where they believe the patient may present a risk of death or serious harm to themselves or others. Some might consider that GPs should be required to advise the police whenever someone with a firearm certificate presents with depression in order that their certificate can be reviewed (and possibly be revoked). Before this position is taken, we must consider the possible repercussions. During the review, a friend of Mark's, who also had a shotgun certificate, said that he always thought about the effect of his actions on this certificate so he would not drink or speed as this could lead to a revocation of his shotgun certificate. We must consider then whether a person with a shotgun certificate might avoid going to their GP if they felt depressed for fear of the impact that this might have. The police must inform the GP within one month if the certificate is revoked or cancelled, or if it expires and is not renewed. The GP can then deactivate the encoded reminder on the patient's record.

3.3.39 The British Medical Council has significant concerns about this new process and is in ongoing discussion with the Home Office (although the essence of these concerns appears to be around payment for the reports rather than the rights and wrongs of doing it)[10]. Mark's GP confirmed to the review that the policy within the practice was for it to be recorded on a person's records if they had a shotgun or firearms licence. The GP confirmed that, when he prescribed the short course of anti-depressants he could see on the screen that Mark held a shotgun licence. He did not feel that there was the need, at that point, to inform the police that he had prescribed anti-depressants as Mark had clearly stated he had no thoughts of harming himself. When asked if he would have taken action if he had prescribed a further course of medication he responded that this would depend upon Mark's mental state. If this had not deteriorated he would not have done so. In taking this stance, the GP was complying with the duty on him to disclose information if they believe the patient may present a risk of death or serious harm to themselves or others.

3.3.40 This review has debated at length, and in detail, the issue around the notification by GPs to the police of patients holding a shotgun or firearms certificate reporting issues such as depression. On the one hand, it could be seen as a material fact in the consideration of a person's suitability to hold a shotgun certificate if they were suffering from stress, depression, anxiety or any other issue that affected their normal reasoning (however temporarily). If one takes that view, then it could be argued that GPs should notify the police of such issues whenever they are aware that the person is a shotgun or firearm certificate holder. However, if the aforementioned became a policy or practice then it is not unreasonable to think that some shotgun licence holders would cease to seek treatment for such issues for fear of losing their licence. In doing this, the risk of danger to themselves or others may, in fact, increase and therefore to introduce such a policy may be counter-intuitive. It is easy in such dilemmas to fall back upon 'each case must be treated on its own merits' but the adoption of a strict policy in either way could have such negative results that it is appropriate to rely on the professional knowledge of GPs about their patients and a good working relationship between the police and health professionals in such circumstances.

[10] Firearms licensing process: GP support guide, British Medical Association, 3rd March 2017

3.3.41 The Firearms and Explosive Licensing Policy of Norfolk Constabulary, published on 9th February 2015[11], states the process for an application (para 11), which is in line with the current Home Office guidance. It is clear from both the national guidance and the local policy that the onus is on the GP to provide any information that they may have. A 'nil return' is not required.

3.3.42 Looking at the history of Mark's shotgun licence it is clear that the police took action when there were concerns about his suitability to possess a shotgun in 2003, with the Firearms Enquiry Officer agreeing with Mark that he would take possession of the firearms for the period of his marital issues. This shows early intervention and good practice by the Firearms Enquiry Officer. Following his arrest in August 2003 this informal arrangement was formalised with the with the firearms licence being formally withdrawn.

3.3.43 When Mark reapplied for his shotgun certificate in December 2005 a report was prepared by the Firearms Enquiry Officer, for the Firearms Manager supporting the application. The police have identified in their IMR that this report included most of the relevant incidents but crucially did not include the incident on 27th April 2004 when Mark made threats to his first wife to 'blow her head off'. If this incident had been included then, as acknowledged by the police, it would have had considerable bearing on the re-issue of the certificate. Although this was 18 months before the application the police confirm that this would have given the Firearms Manager something further to consider and may potentially have led to the application being refused.

3.3.44 The Review is reassured that the ability to search across all police systems is now much more sophisticated and that, if an application were made today, a threat to kill two years previously would have been flagged up and that this would have been likely to result in the application being declined. That said, given that from 2005 to the incident in 2016 Mark did not come to the attention of the police it is not considered unreasonable that in 2016 he was in possession of a shotgun certificate.

The Review feels that although it is clear that, had all the information been available to the officer granting the Firearms Certificate in 2005, Mark would not have been issued with a licence at that point. However, the evidence suggests that Mark would have re-applied at a later date at which point the police would have had no grounds to refuse the application so Mark would have had the shotgun in 2016.

The Review is satisfied that, while the very human response is to say that if he had not been in possession of the shotgun the deaths would not have occurred, Norfolk Constabulary, in reissuing and monitoring his shotgun certificate from 2005 onwards, acted in line both with their own policy and the Home Office guidance.

[11] This is not the most recent iteration of this policy but is referenced as it was in place at the time of the incident

Section Four – Conclusions

4.1 The Review concludes that, on the balance of probabilities, Mark was a man with a history of domestic abuse and controlling behaviour. With hindsight, it could be said that the incidents could have been predicted but, given that neither Mark nor Stephanie were engaged with any services, it is hard to see how the events could have been prevented.

4.2 Whilst acknowledging that Mark displayed a number of the warning signs for domestic homicide, and one of the biggest triggers occurred (in Stephanie's intention to leave), it is felt that this situation may been prevented had Mark not had such easy access to a shotgun.

4.3 The Review is satisfied that, at the present time, Norfolk is making great efforts to provide support for victims of domestic abuse through a range of different avenues and that, in the future, it is hoped that there will be more Domestic Abuse Champions in the general population (such as hairdressers and dentists) who are in a unique position to identify potential victims of domestic abuse who may not otherwise come to notice.

4.4 While the Review wholeheartedly supports the choice of Stephanie's family not to engage in the review and understands their reasons for this, it is very clear that this has resulted in a somewhat 'one-sided' view and that assumptions have had to be made about Stephanie. This has been done as sensitively as possible drawing on research to support the assumptions made.

4.5 During the course of this Review, a significant amount of time has been spent with the surviving children of Mark who are young adults, some with their own small children. What has been very clear is that they have been deeply affected by this situation and continue to deal with the consequences. It is very disappointing that the same level of support is not afforded, by the government, to children of the perpetrators as to children of the victims.

Recommendation - National

That the government reviews its policy with regard to support for children affected by domestic homicide and affords the same level of support to children of perpetrators as is available to children of victims.

4.6 Our thoughts are with the surviving families.

Section Five – Recommendations

5.1 In line with Norfolk's thematic learning framework, which has been drawn from a number of reviews – Domestic Homicide Reviews, Safeguarding Adults Reviews and Serious Case Reviews – the recommendations will be grouped under the following headings:

- Professional Curiosity
- Information Sharing and Fora for Discussion
- Collaborative Working, Decision Making and Planning
- Ownership, Accountability and Management Grip

An additional section has been added for the purpose of this review – National Recommendations

5.2 **Professional Curiosity**

5.2.1 That the GP practices across the county consider having Domestic Abuse Champions in their surgery.

5.2.2 That the hospitals in Norfolk consider having Domestic Abuse Champions in all of their departments.

5.3 **Information Sharing and Fora for Discussion**
No specific recommendations

5.4 **Collaborative Working, Decision Making and Planning**
No specific recommendations

5.5 **Ownership, Accountability and Management Grip**
No specific recommendations

5.6 **National Recommendations**

5.6.1 It is recommended that, despite the strengthening of the latest statutory guidance more work needs to be done to ensure the co-operation of GPs with Domestic Homicide Reviews. As the problem in this case appears to have been, in part, the payment to be made for engagement, it is recommended that either an agreement is reached about payment for these reviews or it is included in the existing contracts.

5.6.2 That the Government reviews its policy with regard to support for children affected by domestic homicide and affords the same level of support to children of perpetrators as is available to children of victims.

Appendix One – Chronology of shotgun licence

16th December 1985	Mark first granted shotgun licence
9th May 2003	Ex-wife reported to police that she had been threatened by Mark
12th May 2003	Firearms officer agrees with Mark that he will voluntarily surrender his firearms 'for a couple of years' whist he is going through his marriage breakup
12th August 2003	Mark received a police caution for possessing an offensive weapon when he was at an address where the police were called to a disturbance. This was not a domestic matter but an unrelated public order offence. The surrender of his firearms was formalised and his licence was cancelled.
27th April 2004	His ex-wife reported further threats to her and her new partner when he 'threatened to blow her head off'. The police issued Mark with a harassment warning.
28th December 2005	Mark reapplied for shotgun licence Threats to his ex-wife in April 2004 did not form part of the assessment
27th January 2006	Shotgun licence granted stating that they should be kept away from the house
2007	Firearms certificate granted Weapons now kept at home
September 2012	Both certificates renewed
July 2016	Incident occurs

Appendix Two – Letter from Home Office DHR Quality Assurance Panel

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Dawn Jessett
Community Safety Assistant
Norfolk County Council

Gary Goose
Independent Chair
Huntingdonshire Community Safety Partnership

27 March 2018

Dear Ms Jessett and Mr Goose,

Thank you for submitting the Domestic Homicide Review (DHR) report for Norfolk to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21 February 2018. I apologise for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this is a good report in which there is a good understanding of domestic abuse, particularly around risk factors. The Panel also commended the breadth and expertise of panel members.

The Panel was very grateful for the letter of 15 November 2017 from Mr Goose which provided a helpful explanation of some of the sensitive issues that emerged whilst conducting this review. The Panel noted and fully supported the chair and the review panel in the actions that were taken in response to the various issues discussed in the letter.

Mr Goose will be aware, through feedback from the Panel in relation to another DHR that he conducted, that the engagement of GPs in reviews can be an issue and that the Home Office is reflecting on what more can be done to raise the status of DHRs amongst health professionals and how we can encourage their cooperation with the process.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Hannah Buckley
Acting Chair of the Home Office DHR Quality Assurance Panel