Domestic Homicide Review Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Rosemary
in December 2017

Report Author: Christine Graham
September 2019

Preface

Western Suffolk's Community Safety Partnership wishes at the outset to express their deepest sympathy to Rosemary's family. This Review has been undertaken in order that lessons can learned; we appreciate the engagement from her family throughout the process.

This Review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this murder in a meaningful way and address with candour the issues that it has raised.

The Review was commissioned by the Western Suffolk's Community Safety Partnership on receiving notification of the death of Rosemary in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

For the reasons outlined later within this report, this Review is considered **inappropriate for publication.** It is intended that it remains **confidential** to professionals within Suffolk and that **learning is disseminated through local mechanisms.**

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this Review, the process and timescales.

Section 2 of this report will **set out the facts** in this case **including a summarised chronology** to assist the reader in understanding how events unfolded that led to Rosemary's death.

Section 3 will provide **overview and analysis of the information** known to family, friends, employers, statutory and voluntary organisations and others who held relevant information.

Section 4 will address **other issues** considered by this Review

Section 5 will provide the **conclusion** debated by the Panel and will consolidate **the recommendations that made.**

Appendix One provides the **Terms of Reference** for the Review

Where the Review has identified that an opportunity to intervene has been missed, or that good practice is shown, this has been noted in a text box.

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Section One – Introduction

1.1 Summary of circumstances leading to the Review

1.1.1 At just after 11.15pm on Saturday 30th December 2017 Suffolk Police received a call from the perpetrator. He informed the police that he had just killed his wife. He stated that she was on the floor between the lounge and the kitchen. He was calm and matter of fact during the call. Whilst he was on the phone, police were dispatched to the address.

1.1.2 When officers arrived, they were directed to Rosemary who was lying on her back in an area between the lounge and kitchen. The officer could not find a pulse and the perpetrator told police that she had been lying there for about an hour and she had not been breathing for the entire time. The officers began CPR and were joined by paramedics who continued to try and revive her until she was recognised as dead.

1.1.3 The perpetrator was arrested for her murder.

1.1.4 When interviewed he made only a prepared statement which was read out by his solicitor. It read as follows:

"I have asked (solicitor) to write this for me and to read it for me. I have lived at (address) for the past 10 years. I lived there with my wife Rosemary. We have been married for 45 years. On Saturday 30th December 2017 there was a disagreement between us. Rosemary got a serrated steak knife and attempted to stab me in the stomach three times. I grabbed for the knife and received cuts to my right hand. I again grabbed at the knife and we stumbled over. I was in fear for my life and during the struggle this terrible accident happened. I never meant to hurt her. I phoned the police. I have no prohibited weapons or ammunition at my property".

1.1.5 A post-mortem found that the cause of death was prolonged compression of the neck. This was supported by bruising around the chin, neck and upper jaw line. There were significant bruises on both of her arms indicative of pressure and restraint caused by hands/fingers to grip. There was also bruising on both hands around the knuckles which could potentially have been caused by her striking out or fighting off the perpetrator.

1.1.6 The perpetrator was charged with his wife's murder and after a trial in July 2018, he was found guilty of murder and sentenced to life with a minimum of 14 years to be served in prison.

1.2 Reasons for conducting the Review

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

1.2.2 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, the perpetrator has been found guilty of the murder of Rosemary. Therefore, the criteria have been met.

1.2.4 The purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.3 Process and timescales for the Review

1.3.1 The West Suffolk Community Safety Partnership (WSCSP) were notified of the Rosemary's death by Suffolk Police on 4th January 2018 which demonstrates a timely notification and good understanding of the criteria for a Domestic Homicide Review.

1.3.2 On 16th January 2018 the WSCSP Domestic Homicide Review Advisory Panel were presented with the details and following discussion the decision was taken to proceed with a Domestic Homicide Review and the Independent Chair and Report Author were appointed.

1.3.3 The Home Office were notified of the decision to carry out a DHR on 16th January 2018.

1.3.4 The first Panel meeting was held on 2nd February 2018. The following agencies were represented at this meeting:

- Mid Suffolk District Council – Community Safety
- Suffolk County Council – Adult and Community Services
- Suffolk County Council – Public Health
- Suffolk Police
- Western Suffolk Community Safety Partnership – Chair

1.3.5 Apologies were received from Suffolk County Council Adult Safeguarding and Bury Women's Aid.

1.3.6 At this first meeting, the Panel considered its composition and it was agreed that the membership was broad enough to give full consideration to the Review.

1.3.7 It was agreed that, as the criminal process was ongoing, agencies would be asked, at this stage to secure their records and prepare a chronology without interviewing any staff that had involvement in the case.

1.3.8 Following the completion of the trial, IMRs were provided by:

- East of England Ambulance Service NHS Trust
- Ipswich and East Suffolk Clinical Commissioning Group
- Suffolk Police

1.3.8 The panel met five times and the Review was concluded in August 2019.

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.

1.4.2 To protect the identity of the deceased, her family and friends, Rosemary will be used as a pseudonym throughout this report.

1.5 Dissemination

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

- All the Review Panel members
- The family who are subject of the Review

1.6 Terms of Reference

1.6.1 The Terms of Reference can be found in Appendix One.

1.7 Methodology

1.7.1 Western Suffolk Community Safety Partnership (WSCSP)was advised of the death by Suffolk Police on 4th January 2018, which represents a timely notification and indicates a good understanding of the requirements in the event of a domestic homicide.

1.7.2 In response to the notification, on 16th January 2018 the WSCSP Domestic Homicide Review Advisory Panel were presented with the details and following discussion the decision was taken to proceed with a Domestic Homicide Review and the Independent Chair and Report Author were appointed.

1.7.2 Gary Goose and Christine Graham were appointed to undertake the Review and the Review Panel met for the first time on 15th February 2018. The Panel met five times and the final meeting of the Panel was on 2nd August 2019. There were discussions and meetings with different agencies involved in the Review outside of the formal meetings.

1.7.3 At the meeting on 2nd February 2018 all members of the panel were present. At this meeting, the process of the Domestic Homicide Review was explained to the Panel with the Chair stressing that the purpose of the Review is not to blame agencies or individuals but to look at what lessons could be learned for the future. Prior to this meeting, the Chair had met with the police's senior investigating officer (SIO) to ensure that Section 9 of the statutory guidance was adhered to.

1.7.4 It was agreed that the following agencies would provide IMRs:

- East of England Ambulance Service NHS Trust
- Primary Care supported by Clinical Commissioning Group
- Suffolk Police

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

1.7.6 At this meeting the Terms of Reference were agreed subject to the family being consulted. It was agreed that the Chair and Overview Report Author would make contact with the family.

1.7.7 Rosemary's sons were approached to contribute to the Review and the Chair met with those who chose to engage. The family were made aware of the support that could be provided by AAFDA (Advocacy After Fatal Domestic Abuse) and one of the sons was supported by an advocate from AAFDA. The family were also offered the opportunity to meet with the panel but did not feel that they needed to do so.

1.7.8 The Chair and Report Author would like to thank Rosemary's family for their willingness to engage with this Review. Their contributions have been invaluable in understanding Rosemary's life. The review also sought to engage with friends identified by Rosemary's family unfortunately, despite the efforts of the Chair and the police we were unable to secure their engagement and the review respects their decision not to be involved.

1.7.9 The Chair and Report Author have met with the family to share the report. A copy has been left with the family to allow them to read the report in peace and at their own pace.

1.7.10 The Community Safety Partnership accepted the recommendation of the Review Panel that this Review is not published. The reasons for this are two-fold. Firstly, the perpetrator in this case was well known locally and therefore any publication will be likely to attract media attention. This would be detrimental to the children and grandchildren of the victim and perpetrator. Secondly, the review is aware that the perpetrator continues to exert negative

control on the family from prison and for him to know that his son had engaged with the review would be unhelpful.

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

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

1.8.4 The following agencies contributed to the Review:

- Suffolk Police
- Western Suffolk Community Safety Partnership
- Suffolk County Council – Safeguarding Adults and Children Board
- Mid Suffolk District Council
- NHS England
- Coroner's Office
- East of England NHS Ambulance Trust
- Ipswich and East Suffolk Clinical Commissioning Group

1.8.5 Some members of Rosemary's family have contributed to the Review.

1.9 Review Panel

1.9.1 The members of the Review Panel were:

Paul Nicholls	Safeguarding Adults and Children Board Manager	Suffolk County Council
Jo Whiting		Coroner's Office
Caroline Sexby	Safeguarding Specialist	East of England NHS Ambulance Trust
Paul Hill	Named Nurse Safeguarding	Ipswich and East Suffolk Clinical Commissioning Group
Christine Hodby	Safeguarding Adults Lead	Ipswich and East Suffolk Clinical Commissioning Group
Melanie Yolland	Professional Lead for Community Safety	Mid Suffolk District Council
Jane Ross	Patient Experience and Quality Lead	NHS England
Heather Hunt	Chief Executive Officer	Bury Women's Aid

DI Ben Clark	Domestic Homicide Team and the MASH Police Team	Suffolk Constabulary
Richard Baldwin	Community Safety Officer	Suffolk County Council
Nichola Bennett	Adult Safeguarding Operational Manager	Suffolk County Council
Victoria Carter	Adult Protection Senior Practitioner	Suffolk County Council
Cllr Joanna Spicer	Chair	Western Suffolk Community Safety Partnership

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 was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.10.2 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 served as Lay Advisor to Cambridgeshire and Peterborough MAPPA for seven years (the maximum tenure legally possible) which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews.

1.10.3 Christine and Gary have completed a number of reviews covering a range of circumstances including murder, manslaughter, murder/suicide, suicide, male victims and those where there is a mental health dimension to the case.

1.10.4 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.[1]

1.10.5 Both Christine and Gary have:

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

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

- Undertaken Home Office approved training in April/May 2017
- Attended the AAFDA Annual Conference (March 2018)
- Attended Conference on Coercion and Control (Bristol June 2018)
- Attended AAFDA Learning Event (Bradford September 2018)
- Attended AADFA Annual Conference (March 2019)

1.11 Parallel Reviews

1.11.1 The inquest was opened on 21st February 2018 and adjourned awaiting the outcome of the trial. At completion of the trial, the coroner did not feel it necessary to re-open the case.

1.11.2 There were no other Reviews undertaken.

1.12 Equality and Diversity

1.12.1 Throughout this 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 The main subjects of this Review are white British. There is no information or inference in any records submitted to this Review that any murder was motivated or aggravated by ethnicity, faith, sexual orientation, linguistic or other diversity factors.

1.12.3 There is extensive research to demonstrate that, in the context of domestic abuse, women are at far greater risk of being victimised, injured or killed.[2] Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[3] Women are more likely than men to be killed by partners/ex-partners. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[4]

1.12.4 Rosemary was 62 years old at the time of her death. Domestic abuse and homicide against older women have been the subject of research and discussion and will be considered in more detail later in the report.

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[2] Smith K et al (2011) Homicides, Firearm Offences and Intimate Violence 2009/10, Home Office Statistical Bulletin 01/11, London, Home Office

3 (Women's Aid Domestic abuse is a gendered crime, n.d.)

4 (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)

Section Two – The Facts

2.1 Introduction

2.1.1 Rosemary was a white British woman and, at the time of her death, was 62 years old. She and the perpetrator were married for over 40 years and had three adult children and a number of grandchildren.

2.1.2 Rosemary had been subject to domestic abuse by her husband, the perpetrator in this Review, over many years. The first incident known to the police involved a loaded shotgun being discharged above Rosemary's head. The couple had separated on at least one occasion some years previously.

2.1.3 At the time of her death, Rosemary was living with the perpetrator but those spoken to as part of the Review indicated that they were in the process of separating again following an affair by the perpetrator with his daughter-in-law.

2.1.4 The perpetrator had been in the military in the past and made much of his role as Royal Marine Commando. He had also been a local councillor.

2.1.5 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 The couple moved around the country on a number of occasions over the years.

2.2.3 Rosemary had a history (dating back to 1976) of attending her GP with pains in various parts of her body including neck muscle strain. She also had a history of high alcohol use dating back to 1993 and a history of depression which is first noted in her GP records in 1976.

2.2.4 1993 is the first time when Rosemary disclosed to a professional that she was experiencing domestic abuse when she attended Accident and Emergency with bruising her face and knees and yellowing bruises on her arms. In December 1993 the perpetrator threatened to kill Rosemary and he discharged a loaded shotgun with the public house that they lived in at the time. A witness told police that it was discharged above Rosemary's head. He was found not guilty of threats to kill and possession of a firearm with the intent to endanger life. He was found guilty of possession of a firearm without a certificate and fined £300 plus £100 costs.

2.2.5 Over the following years Rosemary was seen periodically following attempts to take her own life as well as seeking help with her alcohol use. She was admitted to West Suffolk Hospital in 1994 for a period of alcohol detoxification.

2.2.6 The perpetrator disclosed to his GP in 1994 that he was having marital problems and he regularly (over the coming years) disclosed that he was a heavy drinker. He reported drinking 70 units per week.

2.2.7 The couple separated for a number of years. Although the Review has not been able to establish the exact timescale, it is believed that they separated in 1994 and were together again in 2000.

2.2.8 In 1995 when Rosemary had her own flat with her son, the perpetrator broke into the flat and assaulted her.

2.2.9 The perpetrator is recorded having told his GP that he was drinking heavily on regular occasions.

2.2.10 From 2000 onwards, Rosemary continued to visit her GP with pains in different areas of her body.

2.2.11 In June 2002 the perpetrator reported to his GP that he was having marital problems. He said that his wife was spending long periods on the internet – in chat rooms and playing games. He said that she had email relationships with other men. He told the GP that he had smashed two modems, but he did not know what else to do.

2.2.12 In December 2004 the perpetrator visited his GP with a calf injury caused by pushing a door open.

2.2.13 In 2010 Rosemary was taken to West Suffolk Hospital with bruising and bleeding. She told the police that the perpetrator was responsible for her injuries but withdrew this statement the next day.

2.2.14 Other than a visit her GP in September 2012, Rosemary is not recorded as having any contact with agencies until March 2016.

2.3 Full chronology from 1st January 2016

2.3.1 On 25th March 2016 a call was made for an ambulance to the family home by 111. The call was stood down when the perpetrator reported that he was happy to cancel as Rosemary was no longer coughing. There is no further detail about this call.

2.3.2 There are no further reports of contact until July 2017.

2.3.3 In July 2017 Rosemary called the police as she was arguing with the perpetrator about him using dating apps and he had thrown his phone against the wall. When the police arrived, she said she regretted calling them as it was only a silly argument. Although Rosemary declined to complete the DASH risk assessment the officer did this using their professional judgement and the risk was assessed as STANDARD.

2.3.4 On 24th August 2017 the police received four calls from the family home. As the control room were concerned, they asked for a welfare check to be undertaken by officers. The officer who attended reported that Rosemary advised that she and the perpetrator had a verbal argument earlier as he was having an affair with his daughter-in-law. She explained that the relationship had been violent in the past. The officer attending carried out a DASH risk assessment with her and assessed as MEDIUM. Rosemary said she did not want any

further contact from the police. When the risk assessment was Reviewed by a specialist domestic abuse officer, this was agreed as MEDIUM. Although this specialist officer tried to call her over the next three days, no contact was made. After the police attended, the perpetrator left the address and stayed with his daughter-in-law.

2.3.5 On 28th October 2017 the ambulance service received a call via 111 to attend the address for an overdose by the perpetrator. He had taken a number of tablets 12 hours previously and had vomited and had abdominal pains. He had not attempted to take his own life before. He was taken to Ipswich Hospital. When seen he was deemed to be not suicidal as he said that this was as a result of having drunk too much alcohol. He was not offered mental health services and told to go to his GP for an ultrasound on his liver and advised to reduce his alcohol consumption.

2.3.6 On 30th December 2017 at 11.19pm the police received a call from the perpetrator in which he advised the police that he had killed his wife. He said that he was at his home address and that his wife was on the floor between the lounge and kitchen. He stated that he had suffocated her approximately one hour earlier. He was calm and matter of fact during the call.[5]

2.3.7 Officers were dispatched to the address and found Rosemary as the perpetrator had described in the call. She was lying on her back and, according to the perpetrator, she had been there for about an hour and had not been breathing for all of that time. CPR was commenced but despite the efforts of the police and paramedics Rosemary was recognised as dead.

2.3.8 The perpetrator was arrested and taken into custody.

2.3.9 The post-mortem found that the cause of death was prolonged compression to the neck. There was bruising around her chin, neck and upper jaw line. There were also bruises on both arms, indicative of pressure or restraint caused by hands/fingers to grip. There was also bruising on both hands around the knuckle area which could potentially be from striking out or fighting off the suspect.

2.3.10 Following a trial in July 2018, the perpetrator was found guilty of murder and sentenced to life with a minimum of 14 years to be served in prison.

[5] The call will be discussed in more detail later in the report

Section Three – Analysis

3.1 Information from family and friends about Rosemary and her relationship with her husband

3.1.1 The Review made the family aware of support available to them by AAFDA and at least one family member has been engaged with them. The advocate from AAFDA was able to provide support in the meeting with the Chair of the Review. The input from the family is integral to the Review and understanding what life was like for Rosemary.

3.1.2 The Review has been made aware of a long history of domestic abuse in the relationship both verbal abuse and physical abuse. The couple separated at different times and both had other relationships during these times of separation.

3.1.3 Rosemary would blame herself for the physical abuse that she suffered saying that she had got him in a state. She would say to the children, if he was in an angry mood, that he was just in one of his moods and that they should stay out of the way. Rosemary would always go out of her way to please him.

3.1.4 After her death, Rosemary's friends said that her children and grandchildren were her life and said that she was 'the most bright, beautiful, sweet person you could ever know[6]'.

3.2 Detailed analysis of agency involvement

The chronology sets out in Section 2 details about the information known to agencies involved. This section summarises the totality of the information known to agencies and others involved during the years leading up to the murder. The detailed chronology will not be repeated here; rather this section will provide an analysis of agency involvement.

Throughout the review process consideration has been given to the understanding that exists within organisations across Suffolk about domestic violence and abuse. The Chair and Report Author is aware of a number of other reviews that have been undertaken within Suffolk in recent years from both personal experience and research, and is satisfied that there is a mechanism in place to learn from each review and that knowledge of domestic violence and abuse is increasing throughout the county.

3.2.1 Suffolk Police

3.2.1.1 The police attended the public house where the couple were living on 19th September 1993 after a domestic argument. Rosemary was taken to West Suffolk Hospital with a black eye and minor bruises. No conviction is recorded for this murder.

3.2.1.2 On 26th December 1993 the perpetrator made threats to kill Rosemary. He had a loaded shotgun within the public house in which they lived. A witness said that he discharged the shotgun above Rosemary's head. He was arrested and charged but he was found not guilty of threats to kill and possession of a firearm.

[6] The review was not able to meet with Rosemary's friends. This quotation is taken from a Facebook post. This was despite repeated efforts by both the Chair and Police Family Liaison Officer (who had prior involvement).

3.2.1.3 On 1st May 2010 the perpetrator punched Rosemary in the face during an argument at the marital home. She was taken to hospital and diagnosed with bruising and bleeding. The next day Rosemary withdrew the complaint.

It is noted, both by the IMR author and the Review, that there was a level of blame apportioned to Rosemary in relation to these incidents, almost accepting that because of her alcohol dependence she had brought this upon herself. There has now been a cultural change in how the police respond to domestic abuse, including the completion of DASH risk assessments which were not available then.

3.2.1.4 On 22nd July 2017 the police received a call from Rosemary requesting police attendance. Officers were dispatched to the address and were advised that Rosemary and the perpetrator had been involved in a verbal argument after she had discovered if was using dating apps. She said that she had called the police after the argument had escalated but said that she regretted calling them as it was 'just a silly argument'. She would not answer the DASH risk assessment questions, but the officer did this using his professional judgement and judged the risk to be STANDARD.

3.2.1.5 A month later, in August 2017 the police were called again after Rosemary and the perpetrator had a verbal argument after she had found explicit messages on his phone. She told the police that the relationship had been violent in the past. A DASH risk assessment was completed and was recorded as MEDIUM. She did not wish any further action to be taken. The DASH assessment was reviewed by a specialist officer and again recorded as MEDIUM.

The Review is satisfied that these two incidents were recorded as domestic abuse in accordance with Suffolk Police Domestic Abuse Policy and Home Office Crime Recording standards. It is noted that when the officer attended in July 2017 Rosemary declined to answer any of the DASH questions but that the officer completed the DASH assessment using his professional judgement. This is an example of good practice.

3.2.2 GP for Rosemary completed by Ipswich and East Suffolk Clinical Commissioning Group

3.2.2.1 It was noted, whilst compiling the IMR, that there were substantial gaps in the records for Rosemary between 1983-1990, 1995-2000, 2000-2006 and 2006-2012. The reason for this could not be ascertained.

3.2.2.2 Aside from these periods, Rosemary had regular contact with her GP and presented with muscle pains, minor injuries and skeletal injuries. There are several references in her records to domestic abuse and her dependence upon alcohol, as well as depression and low mood. Rosemary had been an inpatient in the mental health service and had an admission to an alcohol rehabilitation centre.

3.2.2.3 Rosemary had good attendance at her GP appointments.

3.2.2.4 Domestic abuse was noted several times on her clinical records during the 1990s, both with the GP and mental health services. Further investigation or exploration was not undertaken at the time, but it is agreed that this would not have been uncommon at the time.

3.2.2.5 That said, more recently, she was attended in episodes of crisis and distress. Her alcohol intake was considered excessive and was having a detrimental impact upon her family life, according to her husband. She continued to present with pain and discomfort in her body, as well as rectal bleeding.

These more recent interactions provided the opportunity for professional curiosity around the domestic abuse Rosemary was experiencing and there is not the evidence to suggest that this happened. It is also noted that repeated complaints of a similar nature were not viewed collectively but were seen as separate consultations.

It is the view of the Review that these were missed opportunities.

The Review agrees with the IMR author that following up the request for support by the perpetrator with an urgent GP appointment for Rosemary is an example of good practice. However, the review also acknowledges that this could, potentially, have been a further example of control by the perpetrator.

Recommendation One
It is recommended that domestic abuse training for primary care providers covers the importance of asking the question about how things are at home in all health appointments particularly for frequent attenders and that they know what to do when a disclosure is made including appropriate signposting to support services.

Recommendation Two
It is recommended that the Clinical Commissioning Group co-ordinate an action to explore the possibilities of flagging on GP records when incidence of domestic violence, (both for victim and perpetrator where there are no children under the age of 18 at home), led to police interventions or acute medical assessment and/or treatment.

Recommendation Three
It is recommended that the Clinical Commissioning Group works with partners to explore possibilities of flagging domestic abuse concerns on a partner's primary care record where an individual discloses that they are a victim of domestic abuse or they disclose they have displayed domestic abuse related behaviours towards their partner.

Recommendation Four
It is recommended that the Clinical Commissioning Group implements the Safeguarding Adults Board Suffolk Safeguarding Adults Framework training for all primary care and healthcare providers across Suffolk and that primary care participate in the Safeguarding Adults Board county wide audit on effectiveness of this[7].

3.2.3 Suffolk Hospitals

[7] The Framework details for patients who disclose they are a victim or perpetrator of domestic abuse, the local multi-agency services support and advice available and where professionals can signpost or seek professional advice and support.

3.2.3.1 The perpetrator's medical records reveal the incident in 28th October 2017 when he apparently took an overdose and attended Ipswich Hospital. He was not seen by the psychiatric services as he was not deemed to be at risk of suicide. This action, although possibly irrelevant on that night, did not take account of the potential for his mental health to deteriorate on his return home.

Recommendation Five

It is recommended that hospital psychiatric liaison assessment, support and advice is accessible when a victim or perpetrator of domestic abuse presents at A&E, particularly following attempted suicide or drug overdose. This is to facilitate access to appropriate services even where an individual is not presenting as mentally unwell.

3.2.4 East of England Ambulance Service NHS Trust (EEAST)

3.2.4.1 EEAST had been called to the home of Rosemary in March 2016 following a call to 111. The ambulance was then asked to stand down as her husband said that she was no longer coughing. There is no other information available to the Review in relation to this murder.

3.2.4.2 At the end of October 2017, EEAST were called to the family home after the perpetrator said that he had taken an overdose of codeine and paracetamol tablets 12 hours previously. He had since vomited and had abdominal pains. He told the paramedics that he had not attempted to end his life and was taken to Ipswich Hospital. The records note that Rosemary did not know about this incident.

3.2.4.3 On the night of the murder, the ambulance crew arrived at the family home where the police officers were already engaged in CPR. The paramedics took over and advanced life support was carried out for 30 minutes when a decision was taken to cease resuscitation. Rosemary was pronounced life extinct with no heart sounds on auscultation and evident skin mottling.

3.2.4.4 The IMR provided to the Review notes that the staff did not remain on scene to complete their paperwork as guidelines require and senior clinician to Review.

The Review is aware that, following this murder, staff were reminded of the need to ensure a factual and comprehensive account is documented prior to their next tasking.

3.3 Evidence of domestic abuse

3.3.1 We know, from disclosures to the police and medical staff, that Rosemary experienced domestic abuse from the perpetrator throughout her marriage and that this was witnessed by her three children.

3.3.2 We have heard from those who knew the perpetrator that he liked to be the centre of attention. He liked to be the 'big man'. The perpetrator made much of his military background and would talk about his time as royal marine commando. We know that he was actually only in the marines for a relatively short period of time but that he played on the status that this gave him many years later. There are numerous recent photographs of him posing with different weapons, sometimes in army style clothing. We know that he bought a public house that was close to a military base and that most of the customers were people from the military. He liked to have these people around him.

3.3.3 The perpetrator was also, a number of years prior to the murder, a local councillor and it is said that he enjoyed the status that this gave him. At the time, the Review has been told, he only stood for election after a drunken bet and when he was elected, he was known as 'one vote [name]' as he won the election by only one vote. Despite this he was known to relish this role. We know that he was quoted in the media as saying, 'It's superb to be fighting again for my Country, and my People' harking back once again to the status that his military career gave him.

3.3.4 This narcissism, or love of self, also contained a callousness and diminished capacity for remorse or empathy. This is clearly seen in the perpetrator when we consider his 999 call to the police after the murder. Below is a transcript of the call (the perpetrator's words are in red):

Hello can you hear me?
Yes I can hear you, can you hear me?
Yep…
I've er….. just killed my wife.
You've just killed your wife.
Yeah
Okay
… bit different for you tonight I expect
Pause
Happy new year
… and how have you killed her?
Erm…..suffocation really I guess … bit of a bizarre situation ….but you know …. Never mind
OK is it just the two of you in the house?
Er… just the one of us now
Right okay
Well two …. If you like
Okay is there any other sort of issues that the officers need to be aware of when they come into the house? Is there anything dangerous?
No not really. I'm not violent, I'm not nothing
Can I just get you to go and answer the door? I believe we have some officers there. Are you able to go and speak to them?
Okay they're here now are they?
They should be there
Alright, I'm on me way
Okay
I'm on me way as we speak
(Hello)
Ah, hello buddies! How are you, alright?
(Yes I'm well thank you)

3.3.5 The Review has heard the perpetrator described to us as a charming and charismatic man. This charm that made him charismatic was used to not only charm Rosemary but also those around him. The Concise Oxford Dictionary defines the verb 'to charm' as 'to use one's charm in order to influence (someone)' and 'control or achieve by or as if by magic'. This is different from someone who is a 'nice guy', someone who is simply amusing and fun. Charm

is, in fact, manipulative. To use charm is to influence, to bewitch someone, to bring them within your power and ultimately to control them.[8]

3.3.6 This charm manipulated those around the perpetrator to wonder how a man so charming and charismatic could also be an abuser. We see this reflected in the comments made by a friend of the perpetrator after the murder who said, "these things happen". He went on to say, "I still regard [name] as fundamentally a decent man who has found himself in circumstances beyond his control ….. I'm well aware domestic disputes can get out of hand but I feel equally sorry for both [name] and his now deceased wife."

3.3.7 Unfortunately Rosemary did not feel able to confide in anyone during her life and so we cannot hear from her about what the perpetrator was like, but we do have the insight of his daughter-in-law with whom the perpetrator had a three-month affair and is what he and Rosemary were arguing about on the night that he killed her. She describes how she was feeling vulnerable because a close family member was ill in hospital and says that he pursued her relentlessly until she gave in. She describes how he invited her to the council building for a coffee and told her that he had not had sex for six years and asked her if she 'wanted to make him happy'. She refused and left but he pursued her with body building pictures of himself when he was younger. She said she 'had always been intimidated by him as he's very powerful, controlling and manipulative.' She says that he took advantage of her vulnerability and she felt sorry for him.

3.3.8 When she tried to break off the affair, he told her that he needed her, demonstrating his manipulative personality. He continued to pursue her, even after she had ended the relationship, contacting her continually whilst she was in hospital having had an operation. At this point she describes him as becoming obsessive and possessive of her and that she found this quite scary. Even after the affair had come out, he would not leave her alone and would stalk her to supermarkets and baby groups. She also found out that he had been obsessed with her for years and had even compiled a photo collection on his computer, including photos from before he knew his son. He had superimposed her face onto bodies of pornographic photographs. She says that she was scared of him.

3.4 Physical abuse

3.4.1 Over many years, Rosemary visited her GP with muscle pains and minor injuries.

3.4.2 In September 1993 Rosemary told the police that she had been assaulted by the perpetrator and she had bruising to her face, knees and arms.

3.4.3 In December 1993 the perpetrator was charged following an murder in which he had discharged a loaded shotgun over Rosemary's head. Sometime later, Rosemary told her GP that he had 'held a gun to her mouth'.

3.4.4 In May 1994 Rosemary was admitted for alcohol detoxification and she was seen to have old bruises on her limbs which she said were as a result of fights with her husband.

3.4.5 Rosemary told her GP in February 1995 that the perpetrator had broken into her flat and had assaulted her, leaving her with bruising to her chin and eye.

[8] Power and Control why charming men can make dangerous lovers, Sandra Horley, Vermilion, 2017

3.4.6 In June 2002 the perpetrator told his GP that he had got angry because Rosemary was spending a lot of time on the internet and that he had smashed two modems as he did not know what to do.

3.4.7 During 2006 Rosemary attended the GP on three occasions with pains in her body – leg, buttock and thigh and lower back.

3.4.8 In May 2010 the police were called as Rosemary had been taken to hospital after the perpetrator had hit her in the face causing bruising and bleeding.

3.4.9 We know that there are periods of time for which Rosemary's medical records are not available. Therefore, given the murders above, the Review is satisfied to say that there was physical abuse by the perpetrator on Rosemary throughout her marriage that culminated in her being strangled to death by him in December 2017. We can be sure that the perpetrator had thought about harming Rosemary prior to this date. As well as the record of the murder of the shotgun, we know that he told his daughter-in-law that he wished he 'had done the job properly'.

3.5 Emotional abuse and intimidation

3.5.1 We know that on a number of occasions, for example in January 1995 the perpetrator threw Rosemary out of the home. He said that this was due to her drinking.

3.5.2 Rosemary was known to suffer with depression and, on more than one occasion spoke of ending her life.

3.5.3 Although the perpetrator did not like Rosemary to have contact with other people, such as in internet chat rooms, he was happy to use online dating apps which, understandably, upset Rosemary and resulted in her calling the police.

3.5.4 The perpetrator was also content to engage in a relationship with a woman knowing that this would be very distressing for Rosemary, allowing her to see explicit text messages on his phone. The upset that this caused went beyond an extra-marital affair.[9]

3.5.5 The Review is aware that the perpetrator would openly tell people that he had smuggled a gun out of Northern Ireland after he completed his service there and that he had once threatened a man with it when he paid Rosemary too much attention. Whether or not this was true, it had the effect of suggesting that he was capable of such action if necessary.

3.5.6 Rosemary's medical records show that she struggled with alcohol over many years. We cannot know for certain, but it is likely that this was a coping mechanism for her to deal with the abuse that she was facing. We know that the perpetrator would brag to other people about the fact that she was alcoholic. Whilst it is not wholly clear why he would do this, it is likely that he was looking for sympathy from other people or an 'excuse' for the way in which he behaved towards her.

[9] The details of this are known to the Review but are not shared here to protect anonymity

3.5.7 The perpetrator would tell his daughter-in-law that Rosemary was 'a piece of shit' and that she too, was 'a piece of shit, just like her'.

3.6 Coercion and control

3.6.1 Coercive behaviour is an act or pattern of acts of assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour[10]. Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship.

3.6.2 The Review believes that the murder in December 1993 when the perpetrator discharged a loaded shotgun over Rosemary's head was an act of coercion and control as well physical abuse. He wanted her to know what he was capable of and that she would never know when he might do this again. This fear remained with her throughout her marriage.

3.6.3 We know that Rosemary talked about taking her own life when the perpetrator threatened to end their marriage. It is very probable that he had convinced Rosemary that she could not live without him and could not cope on her own.

3.6.4 Rosemary and the perpetrator, we know, separated on a number of occasions and in 1995 when Rosemary had her own flat with her son, the perpetrator broke into the flat and assaulted her. He wanted her to know that he still had control over her even if they were living apart.

3.6.5 The perpetrator, by his own admission to his GP, resented Rosemary having contact outside of the home and did not like her talking to other people in internet chat rooms. He resented this to such an extent that he smashed two modems in an effort to control her use of the internet. This would have prevented her from accessing support online.

3.6.6 The Review has been told that the perpetrator did not like Rosemary going out with her friends and would seek to prevent her from doing this. He did not like her speaking to her close friends, in whom she would confide, and would make her put her phone on loudspeaker so that he could hear all that was being said.

3.6.7 We know that the perpetrator was admitted to hospital a matter of weeks before Rosemary's death. The reason given was that he had taken an overdose. Only the perpetrator will know the truth about this murder, but it is very possible that this was a further way of exerting control over Rosemary or that he might be looking to paint a picture of himself as the victim in the marital breakup.

3.6.8 The coercion and control that the perpetrator exerted was not only over Rosemary but also the rest of the family. On one occasion, he drove the family in the car whilst he was drunk, saying 'tonight Matthew I am going to be Nigel Mansell'. This also demonstrated his narcissistic nature. He liked to be the big 'I am' and liked everyone to look up to him. He liked the trappings that position brought him. The Review has been told that when he stood

[10] Controlling or Coercive Behaviour in an Intimate or Family Relationship, Home Office, December 2015

for election as a local councillor, he did not do this out of any sense of civic duty or desire to help others but that it was a joke made when drunk one night. He became known, by his friends as 'one vote [name]' as he won by one vote. He liked the status and power that this brought him and would say to people 'don't you know who I am?"

3.6.9 The perpetrator continued to exert control over Rosemary after her death, and over his family, by refusing to relinquish his next of kin rights preventing the family from arranging Rosemary's funeral.

3.6.10 **Economic abuse**

3.6.11 We know that in June 2002 the perpetrator smashed up two computer modems which prevented Rosemary from accessing the internet.

3.7 Other issues considered

3.7.1 **Why did Rosemary feel unable to seek help? Or to leave for good?**

3.7.1.1 We know that Rosemary did leave the perpetrator on at least one occasion, and we are told that, after some months apart, they reconciled and we have been told that 'this was meant to be a romantic reunion, but life soon returned to normal'. It is likely that the perpetrator charmed Rosemary into believing that he had changed, that things would be different or that she could not manage without him.

3.7.1.2 Alternatively, as we know that the perpetrator went around to Rosemary's home at least once during this time of separation and forced his way in, she was not free from him even when she left. Sandra Horley says that 'however paradoxical it may appear, women in this situation often feel less frightened staying with their abusers than if they leave them.'[11] At least they know where they are and have an element of control over the situation. It is possible that this is why Rosemary returned to the marriage.

3.7.1.3 We know that at the point of separation a victim is at much higher risk of homicide. We know that the couple had argued about the affair that he had on the night of her death, but we only have the perpetrator's version of what happened. We can only speculate whether Rosemary had told him the marriage was over, but this would have increased the risk of him acting in the way that he did.

3.7.1.4 Mikulioniene and Tamutiene[12] carried out a qualitative study with older victims of domestic abuse and what they found was that women talked about it being 'too late' to flee an abusive relationship. These women spoke about it having been 'too early' when their children were small and time had passed by and, having spent an entire lifetime in an abusive relationship they did not have much time left. Rosemary reportedly told family that, after she had found out about the affair with their daughter-in-law, she decided to stay with him as she 'was too old to start again'. We cannot know, for certain, if this was the case.

[11] Power and Control, Why charming men make dangerous lovers. Sandra Horley, Vermilion, 2017

[12] Mikulioiene and Tamutiene (2019) Perceptions of Domestic Violence Against Older Women, Bows, H (ed), Violence Against Older Women, Volume 1, Palgrave Macmillan

3.7.1.5 What we can be sure of is that Rosemary feared for her life. She posted on Facebook at Christmas 2017,

'Happy Christmas to you all. Hope you are doing well. Have a good day. I hope I will still be here in 2018. We will see.'

3.7.1.6 There is no record of Rosemary ever having sought help from support agencies. We can only speculate about why this might have been. Research with older women undertaken by McGarry[13] highlighted that for many of the women in that study, inter-personal violence was viewed as something which was largely 'private' which went on 'behind closed doors'. The women also said that when they were younger there were not the support services available. It is very likely that women will find it more difficult to report because they have carried this view for many years and/or they have tried, unsuccessfully, in the past to access services and have now given up. It reinforces the need for continual publicity and awareness raising about those services that are available to victims as we know that Rosemary is not alone with only 24% of domestic violence being reported to the police[14].

Recommendation Six
It is recommended that Western Suffolk Community Safety Partnership continues with its efforts to raise awareness about domestic abuse and support that is available. This publicity should seek to particularly target women over 50 years of age.

3.7.2 Reporting in the media

3.7.2.1 There has been a focus over recent months on the inappropriate reporting of domestic homicides in the media. It is noted that, in this case, almost all of the media reports refer to the perpetrator as a 'royal marine commando' giving him some status from having served his country.

3.7.2.2 The media reports also focus on the price of their home with a good number of reports referring to their £400,000 four bedroomed home. This is not relevant and appears to be saying, sublimely that, because of their financial standing they were not typical of those who are victim and perpetrator of domestic homicide. We know that statistically this is not true.

3.7.2.3 The Level Up Campaign has recently produced a set of guidelines for the media when reporting domestic homicide[15].

Recommendation Seven
It is recommended that Suffolk County Council, in conjunction with the Community Safety Partnerships, engages with local media to ensure that they are aware of these guidelines and seek to secure a commitment from them to work within these in future reporting.

3.7.3 Vetting for volunteers working with children and vulnerable adults

[13] McGarry, J (2010), Older women and domestic violence: Defining the concept and raising awareness in practice, Nursing Older People cited in The Invisibility of Older Women as Survivors of Intimate Partner Violence, Bows, H (ed) (2019) Violence Against Older Women, Volume 1, Palgrave Macmillan
[14] Domestic abuse: Findings from the crime survey for England and Wales: Year ending March 2017, using statistics to tell us about victims and long-term trends, Office for National Statistics, 2018
[15] http://bit.ly/2Ep6mEg

3.7.3.1 The Review was concerned that this perpetrator was able to become involved with the Royal Marine cadets despite what we now know about his background. The review sought to establish that the appropriate DBS checks had been carried out. The Local Authority Designated Officer (LADO) was consulted with regard to this matter and in response contacted the Sea Cadets Safeguarding (of which Royal Marines Cadets is a part). They advised that a DBS check was completed and that there is nothing on the perpetrator's safeguarding folder to indicate any problems prior to them being notified of his arrest for murder. They said that if there had been any concerns that needed to be addressed with him that came up on his DBS this would have been recorded. The fact that there is nothing recorded means that the only assumption that can be drawn is that nothing was revealed or, if anything was revealed, it was not recorded, in error. We are simply unable to say which as the record is no longer retained. The disposal of the check is in line with Government guidance on the subject[16].

[16] https://www.gov.uk/government/publications/handling-of-dbs-certificate-information/handling-of-dbs-certificate-information

Section Four – Recommendations

4.1 West Suffolk Clinical Commissioning Group

4.1.1 It is recommended that domestic abuse training for primary care providers covers the importance of asking the question about how things are at home in all health appointments particularly for frequent attenders and that they know what to do when a disclosure is made including appropriate signposting to support services.

4.1.2 It is recommended that the Clinical Commissioning Group co-ordinate an action to explore the possibilities of flagging on GP records when incidence of domestic violence, (both for victim and perpetrator where there are no children under the age of 18 at home), led to police interventions or acute medical assessment and/or treatment.

4.1.3 It is recommended that the Clinical Commissioning Group works with partners to explore possibilities of flagging domestic abuse concerns on a partner's primary care record- where an individual discloses that they are a victim of domestic abuse or they disclose they have displayed domestic abuse related behaviours towards their partner.

4.1.4 It is recommended that the Clinical Commissioning Group implements the Safeguarding Adults Board Suffolk Safeguarding Adults Framework training for all primary care and healthcare providers across Suffolk and that primary care participate in the Safeguarding Adults Board county wide audit on effectiveness of this[17].

4.2 Suffolk Hospitals

4.2.1 It is recommended that hospital psychiatric liaison assessment, support and advice is accessible when a victim or perpetrator of domestic abuse presents at A&E, particularly following attempted suicide or drug overdose. This is to facilitate access to appropriate services even where an individual is not presenting as mentally unwell.

4.3 Western Suffolk Community Safety Partnership

4.3.1 It is recommended that Western Suffolk Community Safety Partnership continues with its efforts to raise awareness about domestic abuse and support that is available. This publicity should seek to particularly target women over 50 years of age.

4.4 Suffolk County Council, in conjunction with the Community Safety Partnerships

4.4.1 It is recommended that Suffolk County Council, in conjunction with the Community Safety Partnerships, engages with local media to ensure that they are aware of these guidelines and seek to secure a commitment from them to work within these in future reporting.

[17] The Framework details for patients who disclose they are a victim or perpetrator of domestic abuse, the local multi-agency services support and advice available and where professionals can signpost or seek professional advice and support.

Section Five – Conclusions

5.1 This is a Review that encompasses many aspects of domestic abuse. The perpetrator in this case not only exerted his control by physical abuse, but also by demonstrating controlling and coercive behaviour, belittling and humiliating his wife by that behaviour. The effect of his sexual affair with his own daughter-in-law upon his own family cannot be understated.

5.2 Throughout the period examined by this Review the perpetrator displayed significant elements of narcissism and self-importance.

5.3 The Review has examined the context in which those agencies who did have interaction with the couple acted. It is clear that some of those early interactions betray the attitude to which domestic abuse was treated in the past. We are confident that organisational cultures within this region (and nationally) have changed sufficiently to make the victim blaming displayed in those early exchanges seem nothing short of appalling with today's view.

5.4 The victim in this case clearly struggled for many years with a dependence upon alcohol and depression/anxiety. She did receive support from agencies, in particular health agencies. No one agency understood quite how difficult life was for her at home. This Review has looked at why she felt unable to follow through with reports to police and other agencies when her husband's behaviour towards her was so appalling. She knew she was in danger and all have been touched by that Facebook message just days before she was killed.

'Happy Christmas to you all. Hope you are doing well. Have a good day. I hope will still be here in 2018. We will see.'

5.5 We have no doubt that the rest of the victim's family loved and cared for their mother very much. They too were 'under the spell' of this deceptive, bullying man. They should not reproach themselves for not having done more, they offered the victim a place to stay and were trying to help her when she was making attempts to break free.

5.6 There is no-one to blame for this murder but the perpetrator himself.

5.7 The recommendations made within this Review will be used to better protect others in the future.

5.8 Our thoughts are with her surviving family and friends, particularly Rosemary's children.

Appendix One – Terms of Reference

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

1 Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by Western Suffolk Community Safety Partnership (WSCSP) in response to the death of Rosemary which occurred on 30th December 2017.

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

1.3 The Chair of the WSCSP has appointed Mr Gary Goose MBE to undertake the role of Independent Chair for this Review. Mr Goose will be supported by Mrs Christine Graham who will be the Overview Author in this case. 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 murder in December 2017 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

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

2.3 Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the murder in December 2017; suggesting changes and/or identifying good practice where appropriate.

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

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

2.6 Highlight good practice.

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 2016).

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 murder 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 if the events in December 2017 could have been reasonably predicted or prevented.

4.2 Consider the period from 1st January 2016

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

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

4.5 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and 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 as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5 Family involvement

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

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

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

6 Legal advice and costs

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

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then WSCSP will be the first point of contact.

7 Media and communication

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