

Executive Summary of a Domestic Homicide Review (the case of T)

Introduction

Community Safety Partnerships are required to undertake Domestic Homicide Reviews (DHRs) when the death occurs of a person over 16 as a result of violence, abuse or neglect from a family member, a partner or a member of the same household.

The purpose of DHRs is to establish any lessons that can be learned about the way that local professionals and their organisations work together to safeguard victims and to prevent domestic homicides in future. The findings of Reviews are published to maintain public confidence, make the processes in place more transparent and to share learning widely across agencies to improve protection for victims.

The Safer Sandwell Partnership has completed DHR Case 5. The Review's Overview Report has been considered and approved by the Home Office Quality Assurance Panel and the findings of the Review can now be published. The deaths in this case have been a personal tragedy for the victim and for the families involved and the members of the Review Panel wish to express their sincere sympathy for their loss and for the distressing consequences they have suffered.

The Partnership has chosen to publish Case 5 in the form of this short summary, out of respect and sensitivity for the privacy of the victim, the perpetrator and their families and because no lessons have been learned which would otherwise need to be shared more widely with the public and other agencies.

Background

The victim (referred to as T) was found dead at her home in July 2013. Police entering the house also found the body of her husband (E) and his suicide note. In it E spoke warmly of his wife but said that he had killed her while his mind had been disturbed by the presence of Japanese Knotweed on land adjacent to their house. He was concerned that this invasive weed would blight their property and make their house unsaleable in future. E said that he had killed his wife because he did not want her to be alone without income after he took his own life. The Coroner's Inquest concluded that T had been unlawfully killed and that E had killed himself.

The Review attempted to understand the causes of this tragedy. None of the information obtained shed any significant light on the reasons for the drastic actions that were taken by E alone. The Review found nothing to indicate that domestic abuse of any kind had taken place in the couple's relationship previously or that either of them had felt a need to seek help from relatives, friends or workplace colleagues. E had no previous history of violent or aggressive behaviour and no reports of distress or the need for urgent help had been made to local agencies, including health services.

E's reported concerns about Japanese Knotweed did not explain his extreme action and no reason was found to blame any party or agency contacted about it. No reasonable person could have anticipated the actions E took and attributed to such an improbable cause.

Conclusions

The DHR concluded that:

- Responsibility for the homicide lies entirely with the perpetrator. His actions were completely out of character, came entirely without warning and had no rationale that can be understood by outside agencies or anyone who knew him.
- The homicide could not have been predicted or prevented by local agencies and no opportunities to intervene were missed. Reluctantly the Panel has had to conclude that a similar tragedy cannot be prevented in future if the same circumstances occur again.
- There was no indication that T was a victim of abuse or that E was abusive before the tragedy occurred.
- There is no evidence that obstacles to disclosing domestic abuse or accessing support played any part in the victim's death.
- All agencies had policies and procedures in place that equipped them to respond effectively when domestic violence was reported. They were not applied in this case because no concerns were raised.
- No lessons have been identified from this case about the way that local services work together to safeguard victims of domestic violence.

The Safer Sandwell Partnership is committed to measures that will help to prevent domestic abuse homicides. Disclosing domestic violence is always very challenging for victims, presenting many risks. Services are working to remove barriers to access and it is their aim to identify victims and to offer support for families at the earliest opportunity. The Partnership's current programme will continue to be implemented as planned to meet this aim.

The Partnership also recognises that domestic abuse is experienced by victims in all age groups and from all communities and social backgrounds. The Partnership's preventative work will therefore continue to be applied broadly, to ensure so far as possible that wherever victims are they can connect with information that raises awareness, offers advice and signposts them to sources of support. A Domestic Violence Campaign has been implemented with this aim.

As no learning points have been identified by this DHR, no new recommendations have been made that will add to the strategies and plans already being implemented in the borough which are overseen by the Borough's DHR Standing Panel.

Addendum to the Executive Summary of a Domestic Homicide Review (the case of T).

The DHR Panel welcomes the Home Office QA Panel's judgement that the Overview Report is adequate. The issues raised in the Home Office letter have been carefully considered by the DHR Panel.

The Panel regarded the perpetrator's suicide note as just one aspect of a much wider picture they were seeking to understand. It was recognised that the note was written from the perpetrator's perspective and that it could not be regarded as an objective presentation of the couple's relationship. Nevertheless it remains one of the very few sources of insight into the mind of the perpetrator and it has therefore been considered in its appropriate context.

The DHR Panel's discussions considered a wide range of possible explanations for the tragedy and for the couple's insular lifestyle, including the potential for coercion on the part of the perpetrator. Discussions with contributors addressed this issue but no evidence was found to support a conclusion that this was an abusive relationship prior to the victim's death. Whilst coercion in their relationship cannot be ruled out, the Panel has based its findings on the facts and the evidence before it and has resisted conjecture without foundation. In the Panel's view this is the only justifiable approach out of respect for the victim and the perpetrator who cannot represent themselves.

The Sandwell Domestic Abuse Strategic Partnership recognises the barriers victims face when reporting abuse. The Overview Report addressed in detail the initiatives taken to raise awareness in the borough and enable access to services for victims. The Partnership is firmly committed to extending this work to all sectors of the community but it remains the case that the victim's circumstances gave no suggestion that she experienced abuse or barriers to reporting it.

With the assistance of the Police Family Liaison Officer the Panel has followed up all available contacts and made positive attempts to engage family members, friends and third parties. Those who wished to contribute were interviewed and were asked to suggest others who could offer further information. Efforts to extend our understanding of the couple's lifestyle and choices were only concluded when there were no further contacts to pursue.

Ken Wynne
Independent Chair, Domestic Homicide Review Panel
and Overview Report Author

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