DOMESTIC HOMICIDE REVIEW 6 EXECUTIVE SUMMARY

VICTIM – SUBJECT A

PERPETRATOR – SUBJECT B

REVIEW INTO THE DEATH IN JANUARY 2015

Completed June 2016

Safer Devon Partnership

I. INTRODUCTION

The review process

1. This summary outlines the process undertaken by the Safer Devon Partnership (SDP) on behalf of South Devon and Dartmoor Community Safety Partnership (CSP) domestic homicide review group in reviewing the homicide of Subject A who was resident in Devon.

2. The following pseudonyms have been used in this review for the victim and perpetrator. The victim is referred to Subject A and the perpetrator as Subject B, to protect their identities. Both were aged 36 at the time of the fatal incident, and both were white British.

3. Criminal proceedings were completed in November 2015 and the perpetrator was sentenced to life imprisonment with a minimum custodial term of seventeen and a half years.

4. The process began with an initial meeting of the SDP DHR review panel on 13 February 2015 when the decision to hold a DHR was agreed. All agencies that potentially had contact with both the victim and perpetrator prior to the point of death were contacted and asked to confirm whether they had involvement with them.

5. None of the 12 agencies contacted confirmed contact with the victim or the perpetrator.

6. The Review Panel set up to consider the DHR was made up of representatives from:
   - Safer Devon Partnership
   - South Devon and Dartmoor CSP
   - Teignbridge District Council
   - NEW Devon Clinical Commissioning Group
   - Devon and Cornwall Police
   - Commissioning Manager for Substance Misuse
   - Public Health Domestic Violence lead

7. No members of the panel had any prior direct involvement with the events or decisions covered by the review. An Independent Chair with knowledge of community safety, partnerships and domestic abuse, and experience of previous DHRs, was appointed to steer the work of the panel and draft the report. The Independent Chair had no personal connection with any of the people involved in the case, or any connection to Safer Devon Partnership or South Devon and Dartmoor Community Safety Partnership, but did serve in Devon and Cornwall Police between 2003 and 2010.

8. The panel drew up an overview report based on police reports, discussions with friends and consideration of the circumstances within the panel. The overview report is available to the agencies responsible for responding to domestic abuse, but it is not in the public domain to protect the privacy of those (other than the victim and perpetrator) whose stories are included in this report. Specifically this includes the children of the family.

Terms of reference for the Review

9. The panel agreed terms of reference which were as follows.
   a) Invite the involvement of the family and as appropriate, friends, to provide a robust analysis of events.
   a) Seek to establish whether there was any agency contact with the victim, perpetrator or other close family members, which is relevant to identifying any record of domestic abuse or indications that Subject A was at risk of violence.
   b) Consider whether, under the circumstances, agency intervention could have prevented the victim's death, given the information that comes to light through the review.
   c) Provide a report which summarises the chronology of events, analyses and comments on the actions of the agencies involved, and makes any required recommendations for improving the way agencies, singly and together, respond to domestic abuse.
   d) Identify how and within what timescales any recommendations will be acted on, and what is expected to change as a result.

10. In the light of an initial analysis of the evidence and risks by the Independent Chair, the Safer Devon Partnership asked the Review Panel to focus on the following questions:

    a) Was there any record of domestic abuse between the couple and known by agencies in Devon?
    b) Was Subject B's drugs production known about by any agency
    c) Did Subject A want to access counselling for concerns around debt, drugs or alcohol? If so, was such counselling available? If so could it have helped?
    d) To what extent, if any, did reported abuse in Subject A's childhood have an impact on her future life?
    e) To what extent was control a factor in the relationship between Subjects A and B? If so what, if anything, took its place when the relationship ended?

CIRCUMSTANCES OF THE HOMICIDE

11. Subject A was murdered during the late afternoon of Wednesday the 28th of January 2015. The exact time of death has not been determined but her telephone communications and the identified movements of Subject B identify the time of death as between 1500 and 1640. Subject A's body was discovered in the premises at about 0310 in the early hours of Thursday 29th January 2015.

12. Subjects A and B were going through divorce proceedings. Subject A told Subject B that she had been to see her solicitor about the divorce the day before and following this wanted to go to the flat to take photographs as part of the valuation process. Subject A had previously asked Subject B for keys to the premises, but had not been given any. The visit to the flat was pre-arranged via text messages between subjects A and B. Subject A had a nine minute phone call with Subject B before they met.

13. Before she went to see Subject B she spoke to her Mother and said that she was feeling quite wobbly. Her mother states that this was the first time that she thought that there might be a problem.

14. Subject B arrived at the flat at around 2.50pm on 28th January 2015. He sent a text to Subject A to say that he was there and that the door was open. Subject A arrived soon after. It is not known exactly what happened in the premises. Subject B claims that Subject A began to take photographs within the premises, using her smartphone.

15. The account of what took place within the premises comes predominantly from the police interviews with Subject B. He chose not to answer questions but through his solicitor provided prepared statements.

16. Subject B told the police that Subject A opened the loft hatch and found a number of cultivated cannabis plants. He said that having seen them, she told him that she would not let him see their children again and that she would bankrupt him, unless he quickly agreed to her settlement terms.

17. Subject B reported a heated argument including shouting and swearing. The argument then became violent as she made to leave the flat and he pushed her against the wall hitting her head and dropping to the ground. In his second interview Subject B reported stamping on her head. He said he moved her body to the lounge, he picked up a flex and pulled it around her neck. He believed that the entire incident took no more than 10/15 minutes.

18. Soon after the murder Subject B went through a complex set of actions apparently designed to hide Subject A's body and to prepare a false trail for the police. He concealed her car, removed the SIM card from her phone and sent text messages implying he was looking for her. He also wrapped her body in layers of plastic and hid it in a shared cupboard on a landing in the house that the flat was part of.

19. Subject B's actions managed to conceal Subject A's body and the murder over the evening of the 28th January. The police found Subject A's body as part of their investigation in the early hours of the following morning, 29th January. Once the body was found Subject B began to admit his involvement in the murder and during interview gave the police his two prepared statements.

ANALYSIS

20. In this tragic case a separation and divorce turned into the murder of a young mother by her estranged husband. There were no apparent precursor incidents, none that could have reasonably predicted the terrible outcome; there was no prior warning of this crime. There had only been minimal reports by friends after the event of earlier domestic incidents. The incidents reported were not sufficiently serious to cause the friends concern and would have been below the threshold that would trigger action by any agency.

21. There is no evidence to suggest that Subject A had been a victim of domestic abuse in prior relationships nor that Subject B had exhibited violence in previous relationships.

22. Neither Subjects A or B sought, or had any reason to be offered, support in respect of domestic abuse. Subject A was participating in local mutual support groups addressing her past misuse of alcohol and drugs.

23. This homicide could not have been predicted by any agency, nor is there any realistic action that an agency could have taken that would have prevented it. There is no intervention that any agency could have reasonably offered to either party which could have changed the outcomes of this case.

24. While the homicide could not have been predicted and therefore not prevented, it is possible that if Subject A had been accompanied by a friend during her meetings with Subject B he might have been deterred from his murderous course of action.

25. If the new law dealing with coercion and control had been in place prior to this murder it is unlikely to have applied in this case. The level of coercion and control exercised by Subject B on Subject A is unlikely to have been considered, by Subject A, nor by the police or CPS as being sufficient to attract a criminal investigation or prosecution. The benefit of that law however, is not simply that it can lead to a prosecution, rather that it allows for conversations about coercion and control and may lead both victim and perpetrator to consider what is happening in their relationship. No agency had any relevant contact with Subject A prior to the homicide, nor any reason to assess whether she was at risk from Subject B. No agency had any relevant contact with Subject B prior to the homicide, nor any reason to assess whether he was a risk to Subject A or to any other person.

26. The police had no interaction with either subject or their wider family; there was no apparent reason for the police to become involved in this situation prior to the murder. Health Services had no interaction, other than routine, with either subject or their wider family; there was no apparent reason for them to become involved in this situation prior to the murder.

27. There was no involvement from Children's or Adults Social Services, nor any apparent need that there should have been.

28. There were no reports, no meetings and no apparent reason to call them so joint services such as MARAC and the relevant information sharing protocols play no part in this case.

29. Local agencies have for a number of years acted together through the CSP and through ADVA to raise awareness of domestic abuse and of the availability of support. There has been less action at local level to signpost help for substance misuse, and nothing directed at families of cocaine users.

30. The mutual aid groups, Narcotics Anonymous and Alcoholics Anonymous, clearly played an important role for Subject A in her attempts to address her previous substance misuse and related problems; she was able to support others going through the process. Given the confidential nature of their work, it is not known if they have any safeguarding policies or similar. It has not proven possible to have any effective engagement with NA/AA at policy level.

Prediction

31. The homicide could not have been predicted. There is nothing in the history of Subjects A or B that would have made any agency intervention appropriate.

32. Agencies were not in a position to see any risk that Subject B posed to Subject A as they had no contact with either about either domestic abuse or substance misuse. So far as can be known, Subject A had not previously been the victim of violence from Subject B. While there was probably some coercive control in the relationship, there is no indication that this was at the level that would attract intervention from any agency. Friends who knew the couple saw nothing that gave them reason to intervene, to seek the intervention of others or to fear for the safety of Subject A. Subject A did not appear to have any such concerns herself.

Prevention – on the day

33. There was nothing on the day that would have led to any intervention that might have prevented the murder. It might have been helpful if Subject A had brought a friend with her to the meeting with Subject B. However, Subject A had no reason to fear harm to herself and may have wished to maintain a degree of confidentiality. There is no Devon policy or advice on participants in divorce proceedings bringing a friend or supporter to meetings with estranged partners.

Prevention – through victim awareness of risk

34. Agencies had no opportunity or reason to assess any risk posed to Subject A by Subject B. There had been no previous agency interaction and while divorce and separation is a known risk factor in domestic abuse, it alone would be insufficient reason to trigger any agencies involvement. Although here was a degree of hostility from Subject B to Subject A, this appeared to be no more than might be expected in a divorce case.

35. There is no indication that Subject A perceived herself to be at risk, and her relationship with her estranged husband was perceived by family and friends to be difficult during their divorce, but not one based on fear. It is unlikely, therefore, that the initiatives taken in South Devon and Dartmoor to raise awareness of domestic abuse would have come to the attention of Subject A.

36. Subject A was seeking a new life; separate from Subject B and from her own old ways. So far as is known she did not seek any professional advice on this, or contact with others facing similar problems. It is not known whether the mutual aid groups helping Subject B, NA and AA pass on information about other services.

Prevention – through interventions with Subject B

37. On the available facts, there would have been no reason for Subject B to attend any perpetrator programme or other course. Had he done so, it might have prevented the homicide. Such programmes have some success in changing attitudes and behaviour but he had no history of violence and would only have entered such a program through self-referral.

WHAT CAN BE LEARNED TO IMPROVE FUTURE PRACTICE?

38. This review has not identified errors in the work of the agencies who might have been engaged. Given the history demonstrated in this review neither subject would have met the thresholds for accessing services for Domestic Abuse.

39. While in theory at least, given the situation as it was in January 2015, either Subject A or Subject B could have accessed support, there was no evident reason why they would have done. Their behaviour did not indicate that there was a perception of risk of domestic abuse. Immediately prior to the events leading to the death of Subject A, if Subject B had engaged support from a friend, counsellor or agency, he may have been able to change the course of events.

40. Subject A had disclosed sexual grooming and abuse that occurred in her early life. This may have had an impact on her later life and her ability to form relationships. It may also have had an impact on her use and abuse of drink and drugs. There is no record that she reported this earlier abuse or sought any help in dealing with it.

41. Ensuring that people know of and are able to access the services which are in place to help needs continued effort. While advice and support groups would have been available to Subject A, she did not appear to consider that she had any need to access these.

42. The mutual support groups Alcoholics Anonymous and Narcotics Anonymous played an important role for Subject A in her attempts to sort out her life. She was receiving almost daily support from these bodies. No other services to address this substance misuse were offered nor sought, nor appeared necessary. The philosophy of these

groups prevents them from contributing to the learning from untoward events. Engagement on this has been sought, but their tradition of anonymity and lack of any infrastructure makes this difficult to achieve. The work undertaken by these agencies is clearly valued by those who access their support. The concern of this review is that should there be other safeguarding issues that are learned about as part of an individual being part of NA or AA, it is not known whether or not these would be passed on, or individuals signposted to other agencies for help.

43. Because the review found almost no interaction between Subject A or Subject B with public sector agencies, or with voluntary agencies, there is no indication of good practice. There is through a very positive sense of community in the area of Subject A's home and active support to her by NA and AA.

RECOMMENDATIONS

44. Because of the absence of contact between the subjects of the review and the relevant agencies there are only limited recommendations in this case.

R1 Ensure effective communication to front line professionals regarding what services are available addressing alcohol misuse, drug misuse and domestic abuse and how to refer or signpost clients to them.

R2 Make information about support groups for families of substance misusers more widely available, recognising that not all will be in contact with treatment services.

R3 The Chair of Safer Devon Partnership to write to Narcotics Anonymous and Alcoholics Anonymous, though their national bodies, requesting that they review their Safeguarding processes and protocols to assist in responding to serious incidents involving anyone attending one of their groups.