Northampton Community Safety Partnership

Domestic Homicide Review

Multi-Agency Executive Summary

Death of X

Northampton Community Safety Partnership

November 2016

Amy Weir
Independent Chair
& Author

Executive Summary – Not to be circulated or photocopied

Preface

Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. This review has been conducted in compliance with the legislation and follows the Guidance.

This domestic homicide review relates to the death of a female adult, known as X, in this report, who was murdered on 23rd March 2015 and to her husband, known as Y in this report, who was charged with and found guilty of her murder in January 2016. Y was convicted of murder on 29th January 2016 and was sentenced to life imprisonment with a minimum tariff of fifteen years.

The Review Chair and the Panel wish to acknowledge the distress caused and to express sympathy for the family of the victim. The death of any person in such circumstances is a tragedy and, in this case, the family continue to grieve and to come to terms with the longer term effects of their loss.

The Panel would like to thank all those who have contributed to the review for their time and support in assisting with the review process.

The victim was of White British ethnicity. She was aged 49 years at the time of her death.

Her husband Y is also of White British ethnicity. He was 49 years at the time of the murder. He was a serving police officer at the time of this incident with 28 years of service.

The review has been conducted with an impartial, fair, balanced and thorough approach. There has been appropriate challenge where necessary. All of the agencies involved have worked hard to identify learning for their agency. This will be taken forward to improve their service for the future.

The death of X was tragic and the Panel has exercised appropriate compassion and sensitivity in relation to the circumstances which have led to the review.

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Part 1: Introduction

1.1 The Community Safety Partnership (CSP) has a statutory duty to enquire about the death of persons where domestic abuse forms the background to the homicide and to determine whether or not a review is required. The statutory guidance states that a domestic homicide review means 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 learned from the death.

The purpose of DHRs is to consider the circumstances that led to the death and to identify where responses to the situation could be improved in the future. Lessons learned from the reviews will help agencies to improve their response to domestic abuse and to work better together to prevent such tragedies from occurring again.

1.2 The review panel

1.2.1 Following the death of X, Northamptonshire Community Safety Partnership agreed that the criteria for a Domestic Homicide Review were met and a panel was appointed to oversee the process. The period considered by the review was 1st September 2013 to the end of March 2015

1.2.2 A local review panel drawn from local agencies was set up to assist the Independent Author and to oversee the review.

1.2.3 The Independent Chair and Author, Amy Weir, was appointed at an early stage, to carry out this function. She has many years' experience in writing Serious Case Reviews as Chair and Author. Prior to this review process she had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. Amy has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.2.4 The following agencies contributed to the Domestic Homicide Review by the provision of reports, correspondence and chronology. Single agency Individual Management Reports (IMRs) or statements of involvement were received from relevant agencies. These were given careful and thorough consideration by the Review Chair and Panel.

NHS England (GP involvement) Northamptonshire Police Northamptonshire Healthcare NHS Foundation Trust East Midlands Ambulance Service Northamptonshire Children's Services – children's social care. Northamptonshire Children's Services – education

1.3 Purpose of the review

The purpose of the review was to:

- Establish the facts that led to the incident in March 2015 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.

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

- Establish whether the agencies or inter-agency responses were appropriate leading up to and at the time of the incident in March 2015.

- Establish whether agencies had appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

1.3.1 Family members of the victim and perpetrator were contacted on 3 separate occasions during the process asking if they would like to contribute to the review. The perpetrator was also contacted so that his views could be obtained.

Family members of the victim declined to take part, and no response was received from the perpetrators family. The perpetrator initially expressed a wish to contribute, but cancelled the arranged appointment at very short notice.

Part 2: The Facts

2.1 Background

2.1.1 This review has been conducted in relation to the murder of X by her husband Y at the matrimonial home in Northampton in March 2015. Y was found guilty of murder in 2016.

2.1.2 He was jailed for life with a minimum term of 15 years to be served.

2.1.3 With a unanimous verdict, the jury appears to have believed that Y had beaten his wife to death when he lost his temper and went into an uncontrolled rage.

2.1.4 There was no direct evidence of domestic violence and abuse between them. Y did suggest that X had abused him but there is no evidence to support this allegation.

2.1.5 Following her death, Y lied repeatedly to police, doctors and the prison chaplain about how he had received his self-inflicted knife wounds.

2.2. The Facts of the Case

2.2.1 X and Y had met in January 2012. They started living together some months later. X's son also moved in to live with his mother at Y's home. X and Y were married in May 2014.

2.2.2 Y had had significant problems at work during the last few years. He had been a Police Officer for more than 20 years but in the last five years, various concerns had arisen about his behaviour and professional conduct.

2.2.3 It seems that between 2010 and 2012, Y was drinking heavily and may have become alcohol dependent. The consequences of his alcohol consumption on his work as a police officer were not fully considered. The police doctor who saw Y but did not carry out a full assessment in relation to possible the work-related impacts of this behaviour. There was no contact with Y's GP to discuss the concerns in 2010. In 2012, a wait and see approach was adopted by his employer.

2.2.4 In November 2012, Y was subject to a disciplinary investigation in relation to breaches of professional standards. As a result of the investigation and his own admission of error, he was subject to a disciplinary hearing in September 2013 when the case against him was found to be proven.

2.2.5 Initially in November 2012, Y declined a referral for the stress at work he was experiencing to the police occupational health unit (OHU). In April 2013 he was referred to OHU.

2.2.6 From September 2013, Y appears to have experienced increasing levels of stress which he discussed with his GP. His line manager was concerned about his health and well-being which were being affected by family problems – unrelated to his relationship with X - and concerns about his son as well as the protracted disciplinary procedure at work.

2.2.7 X also reported to the GP that she felt low and that Y was stressed from the disciplinary investigation at work. Y was on sick leave. He was prescribed anti-depressants and was having counselling which he reported was improving his capacity to cope.

2.2.8 In February 2014, a Police welfare visit was made by his Police Welfare Single Point of Contact (SPOC) to Y at home. His return to work was discussed. He was also to be seen by OHU and was seen at the beginning of March. A phased return to work was suggested and agreed.

2.2.9 In March 2014, Y told his GP that he thought he was suffering from Post-Traumatic Stress Disorder (PTSD). Y told the GP that he had been researching his symptoms on the internet and, as a result, he believed he was suffering from PTSD. He said that he was about to return to work but was struggling with this. A further welfare visit was made to his home and Y was told where he would be working on his return.

2.2.10 Y was seen by a member of the Community Mental Health Team at the end of March 2014 following referral made by the GP. The assessment of the practitioner he saw was that Y needed counselling and contact details for counselling were provided.

2.2.11 Towards the end of April, Y was informed that the work unit which he had been informed he was to join was to be disbanded. He was therefore uncertain about his future. He was seen by OHU and expressed his concern about this. He also said that his partner was suffering symptoms of stress. Y wrote to the OHU. He said that the counselling service was helping him but that he did not want any more sessions.

2.2.12 In May 2014, X and Y married. The honeymoon did not apparently go well according comments made by X and Y. When Y went to see the GP in June 2014, he said that he and X had discussed divorce whilst they were on their honeymoon. During their honeymoon, X wrote to the Police saying that she wanted to complain about the way Y was being treated at work. She said they were on honeymoon and it was being ruined – she said he needed therapy. She said she could not bear to see him like this and wrote "I don't know I can cope much longer".

2.2.13 In June 2014, Y told a colleague that his wife had suffered a breakdown "before him" and that she was very vulnerable. He said she was "a mess" and that she had lost confidence in the Police. This related to the problems which had emerged in finding Y a work placement which he wanted. On 11th June he said that he was going off sick. He later stated that he did not want to return to work until his counselling had been completed. This contradicted the position he had taken in May 2014 when he stated he did not want counselling.

2.2.14 His SPOC stayed in touch with Y and remained concerned about his well-being. He carried out home visits and kept in touch by email. In July, Y was negative to the SPOC about his wife for the first time. Previously he had been protective towards her and spoke about seeking to help and support her.

2.2.15 In October, Y told his SPOC that he was about to file for divorce "under the grounds of domestic abuse". He said he had decided to move out. Two days later, he sent a text saying that he was a very happy and relieved man and that he could now go back to work as his wife "had turned a corner, in fact we both have." He was apparently no longer considering divorce and he confirmed that no domestic abuse had occurred between him and his wife.

2.2.16 In December, Y sent a text to his SPOC to say that his son was moving back in for "witness protection." He had already told him that the divorce papers were in the car. Y said it was X who was the problem and it was just a matter of sorting the divorce out.

2.2.17 A few days earlier X went to the GP to ask for an increased Hormone Replacement Therapy (HRT) dose; she said there was still stress, her mood was low and her libido was still an issue.

2.2.18 In December 2014, Y sent an email to his police SPOC saying that his wife had accepted that it was all over and she had acknowledged her illness at last. He wrote that he "won't actually feel safe until she goes as she is in a very bad place but I finally admitted that I could not save her."

The same day he emailed the OHU to ask whether his wife could be provided with counselling as they were divorcing and she was "struggling with a few issues." He was provided straightaway with information about the counselling available to her as his wife.

2.2.19 On 2nd January 2015, Y emailed his SPOC to say that X had started a job and had gone "out in public". He said he would be "daft to give up on her" now. On 18th January, Y told his police SPOC that he was much better. This was mostly due to the fact that "my wife turned a corner herself which was heavily linked to my anxiety issues and also feeling comfortable at home".

2.2.20 X went to see the GP to discuss her menopausal symptoms again in February 2015. She said she had separated from her husband before Christmas but she said that things had improved. Her husband's son had been staying with them and there had been problems and arguments as a result of this.

2.2.21 A month later Y murdered X at home.

Part 3: Analysis

3.1 The IMRs have identified areas where lessons have been learned from the case about the way services worked together, and separately, in this case. However, there appear to have been limited opportunities to intervene to prevent the murder of X given that there were few, if any, advance indicators. Applying hindsight, it is perhaps possible to identify some possible indicators of how risky their relationship could be but at the time this was not clear at all.

3.2 There is only one direct, historical reference to domestic abuse prior to Y's relationship with X. His second partner alleged that in 2011 he had assaulted her when under the influence of alcohol; but she did not make this allegation till 2013 and two years after their relationship had ended. Y alleged that he was being abused by his wife but he only referred to this obliquely and without details to support this statement.

3.3 There are possible indicators that domestic abuse would develop towards the end of X and Y's relationship. Y appears to be a very intense, self-absorbed person and in his trial evidence was given of his control and degradation of X. He had recorded her saying that she was scared of him because his behaviour was so changeable – she said he could be Jekyll or Hyde. When he became very jealous towards the end of their relationship, a witness at his trial gave evidence that he monitored the mileage she did in her car. None of this was known to the agencies involved with them at the time.

3.4 There is some historical evidence that Y had a significant alcohol misuse problem some years earlier. There were two incidents at work in 2010 and in 2012 when he was accused of being under the influence of alcohol at work. He also spoke to his GP about his high alcohol intake at that time and sought advice on how to reduce it. During his time with X there is no suggestion that he was drinking excessively.

3.5 It appears that the relationship between X and Y had become troubled after they married. They were both anxious people and Y's difficulties at work seem to have tipped the balance of his coping capacity. They had both disclosed having periods of depression to their GPs even prior to their relationship. In giving evidence at his trial he described his relationship with X as mixed being "harmonious, difficult, challenging".

3.6 As well as the work related stresses which Y experienced, there were more personal problems in their marital relationship. X went on several occasions to see her GP about her menopausal symptoms and her lack of libido. Y accompanied her to some of these appointments.

3.7 X and Y argued about family matters – about their sons. X's son was living with the couple. For a time, Y's son was also living there but, after a disagreement, he left and was homeless. There is no detail available about the nature of these arguments and they did not seek any external help to resolve them.

3.8 From October 2014, major issues seem to have emerged between X and Y and divorce was again being discussed. They parted briefly at Christmas 2014. Most of the information about what was happening comes from Y's perspective and retrospectively from evidence at his trial. There were ups and downs after Christmas but evidence from the trial has suggested that from February 2015 the relationship was deteriorating further. A witness told the Court that Y was monitoring X's behaviour and he was suspicious of what she was doing. The jury was told that Y had typed up notes about his relationship with X saying that he was "ready to explode" and that he had "scared X", who had called him a "Jekyll and Hyde" character.

3.9 Even on the day of the murder, there was no initial indication of what would happen later. Y went shopping at the supermarket and sent a few texts before returning home. Y was on a day's leave and had planned to finish painting his porch. There had been discussion about moving home and on that day X was looking at houses on the internet. Suddenly, Y's behaviour seems to have become irrational and he carried out a full attack, without any inhibition, on his wife. From the evidence available, the events which happened that day could not have been foreseen.

3.10 During the trial, it was recorded by the Judge that Y showed no regret or emotion even when he was being cross-examined. Y appears to have a complex personality; he was a long serving and decorated police officer but is now a convicted murderer who had no hesitation at his trial in making an attack of his wife's behaviour and character.

3.11 The Police, as his employer, tried hard to support Y through his disciplinary. It took a long time for this to be concluded but this was not outside the procedural expectation. Subsequently, his SPOC officer kept in touch with him on a regular basis and sought to advise and support him. The GP referred Y for help with his anxiety and prescribed medication. Y did not admit what he had done and did not take responsibility for his behaviour; he alleged that his wife had attacked him and that he had been provoked.

3.12 X also received advice and treatment from the GP regarding menopausal issues. These symptoms could have been further investigated. This problem was a source

of great frustration to Y though he did not disclose the extent of this until his trial. The problem was identified as X's but more in-depth consideration of the relationship issues between them may have been useful.

3.13 The attack on X by Y may have resulted from an accumulation of tensions, stresses and frustrations on Y's part. From October 2014 he was telling his SPOC that his wife had mental health problems and that he was frightened of abuse from her. As soon as the SPOC questioned him about the domestic abuse he backed off, downplayed it and said things had improved. Earlier in 2014, he had told his GP that he was "bottling things up and felt guilt". He said he could not live with the guilt of information he was "bottling up". He would not specify what he meant. It is possible that Y was finding it impossible to live with his wife and was considering what he could do for many months. The SPOC acted quite appropriately and followed up the concerns Y had raised; when he would not be more precise about exactly what he meant there was no further action she could take.

3.14 However, it may be that the attack on X was a one-off spontaneous event. There are many examples in his contact with the SPOC and with the GP to suggest that Y was not always open and transparent about what he was thinking or doing. There is good evidence that the SPOC, the GPs and the mental health services with whom Y and his wife were involved did all that they could to be supportive and to help solve the difficulties they were experiencing. Y does not always seem to have fully disclosed what was happening and his only partial compliance with what the professionals involved were seeking to do made it difficult for them to help. His continued lying after the murder, his denial of any responsibility and lack of any emotional reaction or regret may suggest that there was more deliberate intent, and possibly planning, when he killed X. At the time, none of those in contact with him could have seen the overall pattern and he was skilful in defusing any concerns which he aroused.

3.15 For any of those who were in contact with Y, it would have been very difficult to identify any potential risks which were there given Y's reluctance to open up and tendency to give different versions of events at different times. X's death therefore could not have been predicted or prevented.

3.16 On balance, with the knowledge that was available at the time, all of the agencies involved with the family did their best to support X and Y. The single agency and inter-agency responses provided were appropriate leading up to and at the time of the incident on 26th March 2015. There are some minor improvements which they intend to make or have already made to their practice and procedures.

3.17 The agencies involved had appropriate policies and procedures in place. In this case there were no significant antecedents or prior indications of domestic abuse to which the agencies could or should have responded.

3.18 Research in relation to domestic abuse relevant to this case has been sought but the underlying nature of the problems in this case do not appear to be typical of cases researched to date.

Part 4: Conclusions & Recommendations

4.1 Findings and Conclusions

4.1.1 This is a tragic case which resulted in the death of a woman with a son and a close-knit family who has found it difficult to come to terms with losing her.

4.1.2 The GPs and the Police Service sought to support both X and Y during stressful times. Y was referred to mental health and counselling services but he did not fully engage with the help on offer. Y did not easily or openly disclose his true feelings and on one occasion his GP described him as talking “in riddles”. There is good evidence that the local services accessed by Y and X did their utmost to improve the problems which the couple shared.

4.1.3 From the evidence of his behaviour and his contact with practitioners, Y appears to be a rather self-obsessed, preoccupied and aggrieved man who lacked the resilience to cope with the problems he had. He was disappointed in his marriage to X. Although, at some points, he could be protective towards her. At other times he was highly critical and behaved in an overbearing manner towards her to the point where she became frightened of him. At the same time, he alleged that he was frightened of her though we do not know what worried him.

4.1.4 Given Y’s controlling behaviours and inconsistent presentation, I think it is highly unlikely that it could have been predicted that he would murder X. The description of his obsessive behaviours and preoccupation with his wife just before her death may indicate the seriousness of the breakdown of their relationship. The extent of the apparent deterioration in their relationship over the last few weeks was not known to the professionals who were involved.

4.1.5 For the same reasons that Y was difficult to read and did not present in a consistent manner, I do not think that X’s death was preventable. If she had sought more advice and support about the difficulties she was experiencing, then maybe some preventive intervention may have been possible.

4.1.6 Where possible improvements have been identified, the agencies involved have made or are making the required changes. These are minor improvements which are unlikely to have made a significant difference to the outcome in this case.

4.1.7 Considering the difficulties for agencies in being able to obtain a full picture of what was happening between Y and X, it is the conclusion of this review that the death of X could not have been foreseen or prevented.

4.2 Recommendations for single agencies

4.2.1 The following recommendations have been made by each of the agency involved with this case:

4.2.2 NHS England Central Midlands (GP)

4.2.2.1 Reminder to GPs regarding parental mental health issues and how an adult's mental wellbeing will affect family life.

4.2.2.2 Review of safeguarding training to draw in learning from this case regarding Mental Health concerns and how that may influence domestic abuse.

4.2.2.3 The GP leads for safeguarding will receive specific domestic abuse training as part of their annual safeguarding training update commissioned by the CCG/NHS England.

4.2.3 Northamptonshire Police

4.2.3.1 To develop an educational publicity campaign within the workplace defining domestic abuse, its known frequency and the statistics that show that it will be affecting the lives of their work colleagues.

4.2.3.2 To consider the development of a formal and confidential / anonymous reporting process allowing employees to submit concerns they may have about domestic abuse happening to a colleague.

4.2.3.3 These recommendations should be considered to bring the 'hidden crime' of domestic abuse out into the domain of the workplace to promote confidence in reporting and that the organisation will act positively to the reports.

4.2.3.4 Greater consideration should be given to the placement of officers/staff on restricted or 'light duties' taking account of their circumstances, the number allocated to a department and the additional stresses that can be caused to line managers.

4.2.3.5 This recommendation is suggested in order to reduce the impact on those that have to manage the individuals and to prevent or reduce the automatic placement of personnel into departments that can take place without knowledge of wider implications.

4.2.4 Recommendations from this DHR for the Community Safety Partnership

4.2.4.1 More direct sharing of plans and information for individuals between occupational health services, GPs and mental health should be promoted – immediately.

4.2.4.2 Community Safety Partnership to consider providing advice to local employers about the possible consequences of stress at

work for family relationships including the possibility of domestic abuse.

4.2.4.3 DHR Overview Report to be shared with other relevant local partnerships – Adult Safeguarding Board and the Health and Well-Being Board. Dates of meetings to be confirmed – within 3 months.

4.2.4.2 Community Safety Partnership to link in with Countywide Strategic IPV Board in order to develop approaches in raising awareness and educating communities on controlling or coercive behaviour in an intimate or family relationship which causes someone to fear that violence will be used against them.

4.3 Progress on the Actions following the Recommendations

(These are being monitored regularly by the Community Safety Partnership)

4.3.1 Debrief and learning events to be held for practitioners re findings of this and other recent DHRs. Completed.

4.3.2 Being Well - My Action Plan (for GPs with patients) to be introduced and used for sharing with other agencies including occupational health services – where relevant. Nearing completion.

4.3.3 Community Safety Partnership to hold a conference about domestic violence and abuse for local employers to include occupational health services. Planned for April 2017.

4.3.4 Community Safety Partnership to include within its Domestic Violence and Abuse Strategy a public health pledge for all local agencies and employers to adopt and follow. This is in progress.

4.3.5 DHR Overview Report to be shared with other relevant local partnerships – Adult Safeguarding Board and the Health and Well-Being Board. Completed.

4.4 Conclusions

There has been considerable learning from this case for the local agencies in Northamptonshire. Even though it is not likely that this murder could have been predicated or prevented in the circumstances of this case, it has made agencies, and particularly the Police, consider the responsibility to be watchful and vigilant in considering the response to familial relationships of employees.

Amy Weir
Independent Chair & Author