DOMESTIC HOMCIDE REVIEW

OVERVIEW REPORT

INTO THE DEATH OF ADULT 1

Independent Author

Cherryl Henry-Leach

“My mum was the most loving person you could ever meet: if she took you under her wing then she was so caring and supportive. Mum always put others before herself. She liked to shop and keep herself fit; she enjoyed the football. But she would always make time to be sure we did girlie things together. Some of my best memories of her are when we were on holiday. When it came to Christmas and birthdays she would always go the extra mile…with extra surprises…I couldn’t have wished for a better mum. She was beautiful. Inside and out.”

“Her smile could light up a room and she was so warm to everyone.”

“After we lost her, [some local children] planted sunflowers as a tribute to her. Sunflowers were one of her favourite flowers and they will now always remind me of her love for life.”

The Panel formally express their sincere condolences to the family of Adult 1 and her friends.

Contents

1. Introduction

1.1. Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004. This report of a Domestic Homicide Review examines agency responses to Adult 1 who was a resident of Leicestershire prior to the point of her murder in April 2018.

1.2. The Chair and Panel express its sincere condolences to the family of Adult 1.

1.3. The main people referred to in this review are:

- Adult 1
- Adult 2
- Adult Female (AF 1) – Adult 1's surviving child, and stepdaughter of Adult 2
- Adult Male (AM 1) – the father of Adult 2.

1.4. In the authoring of this report, a number of individuals who knew Adult 1 and Adult 2 agreed to be interviewed. Their contributions are referenced where appropriate throughout this report. Their identifications have been coded. The Panel extends it thanks to:

- Sister 1
- Sister 2
- Friend 1
- Friend 2
- Friend 3
- Friend 4
- Adult Male (AM 2) – partner of Adult Female (AF1)
- Employer 1.

1.5. The Panel would also like to extend its thanks to the Police Family Liaison Officer for their assistance in this review which was invaluable.

2. Establishing the Domestic Homicide Review

2.1. Background

2.1.1. In the spring of 2018, Friend 1 contacted Leicestershire Police and requested they attend the home of Adult 1 and Adult 2. Friend 1 explained to the Police that they lived close to the couple's home and AF 1 had arrived home from work and found Adult 1 and Adult 2 deceased in a downstairs room. AF 1 had then attended the home of Friend 1, requesting that Friend 1 phone the Police.

2.1.2. The Police attended and found both Adult 1 and Adult 2 in the front room of the property. Both were deceased. A note was found in the kitchen addressed to AF 1 and the content suggested it had been written by Adult 2, admitting the murder of Adult 1. It was quickly apparent to the Police that Adult 2 had ended Adult 1's life before taking his own.

2.2. Decision Making

2.2.1. The statutory requirement to complete a Domestic Homicide Review rests with the Community Safety Partnership (CSP) for the area in which a homicide takes place. In Leicestershire and Rutland, local procedures are in place for the CSPs to commission a review through the joint Safeguarding Adults Board and Safeguarding Children Partnership[1] Case Review Group.

2.2.2. In this case, the CSP was notified of the deaths of Adult 1 and Adult 2 by Leicestershire Police, who proceeded to report to HM Coroner.

2.2.3. A scoping exercise was undertaken by the Leicestershire and Rutland Safeguarding Partnerships Business Office. Many agencies confirmed they had no contact with Adult 1, Adult 2 or AF 1.

2.2.4. Minimal contact was confirmed by two agencies, who submitted Individual Management Review reports:

- Leicestershire Police
- GP Surgery 1.

2.2.5. The Leicestershire and Rutland Safeguarding Adults Board and Safeguarding Children Partnership Case Review Group recommended to the Community Safety Partnership on 21st May 2018 that the case met the criteria for a Domestic Homicide Review, with an agreement that a Domestic Homicide Review would be undertaken. The Home Office was informed of this decision on 6th June 2018, when the responsible Safeguarding Board Officer returned from annual leave. Agencies involved in decison making and setting the Terms of Reference are listed below.

2.2.6. In line with the statutory guidance for the undertaking of domestic homicide reviews, the family were offered the opportunity to comment on the report before it was finally agreed by the Panel. Unfortunately, due to the national period of Covid-19 restrictions, this could not be arranged until restrictions and the family's circumstances enabled this. This did not stop the Partnership from progressing the learning and recommendations from the review, and this is reflected in the action plan.

2.3. Parallel Processes

2.3.1. Given the postmortem confirmation to Leicestershire Police that Adult 2 took the life of Adult 1 and then his own, no criminal justice proceedings were required in this case.

2.3.2. HM Coroner held an inquest on 5th February 2019. This concluded the coronial proceedings. HM Coroner confirmed the Adult 2 did indeed take the life of Adult 1 and then his own life.

2.3.3. During the Domestic Homicide Review, HM Coroner agreed the Panel could have access to HM Coroner's file through named individuals. The Chair

[1] At the time this review was commissioned, this was the Local Safeguarding Children's Board.

agreed that this would be undertaken by the Overview Report Author and the Leicestershire and Rutland Safeguarding Board Officer coordinating this review. The findings from the review of HM Coroner's file are referred to where appropriate in this report.

2.3.4. HM Coroner also noted, thorough her officer, that the inquest could have been informed by the Domestic Homicide Review. This has resulted in HM Coroner and the Safeguarding Partnerships Business Office reviewing the pre-existing protocol to ensure that future inquests will be informed by Domestic Homicide Reviews in the appropriate cases.

2.4. Involvement of Family, Friends and Ongoing Support for Family Members

2.4.1. Introductions to AF 1, Sister 1, Sister 2 and AM 1 were very helpfully facilitated by the Police Family Liaison Officer. This enabled these persons to consider if they wished to contribute to this review and all elected to do so. Their views are documented, where it is appropriate, within the body of the report.

2.4.2. Initially, AF 1 advised that they wished for the deceased to be referred to by name in the Overview Report. AM 1 advised that they did not want Adult 2 to be named. AM 1 was a vulnerable adult by definition of the Care Act and also expressed their concern that their community had already stigmatised them because of the actions of this son. At the request of the Case Review Group, who felt there was a need to ensure a compromise amongst surviving relatives, this was revisited with AF 1, who preferred that the deceased be referred to as Adult 1 and Adult 2 in this report.

2.4.3. AF 1 specifically requested the Panel meet and invite Friend 1 to contribute to this review due to the very close friendship Friend 1 shared with Adult 1. AM 1 met with the Overview Report Author but declined to meet with the Panel and expressed a wish not to be contacted in the future, due to his old age and a need to remember Adult 2 in the way that he wished to. AF 1, Sister 1 and Sister 2 expressed a willingness to meet with the Panel and this was facilitated. At the request of AF 1, Friend 1 was also invited to meet with the Panel. This enabled them to share their recollections of happier times with Adult 1 and Adult 2 with the Panel, and also share photographs of Adult 1.

2.4.4. It was confirmed by the Police Family Liaison Officer that AF 1 was receiving support from the Victim Support National Homicide Service. They have contined to keep in touch through this process and have liased with the Leicestershire and Rutland Safeguarding Partnerships Business Office for updates

2.4.5. When Sister 1 was interviewed as part of this review, it was evident that she required support to come to terms with the loss of her sister and the very personal memories this had evoked in relation to the sisters' childhood experiences. A referral was made to the Victim Support Homicide Service who initially allocated Sister 1 to the same worker supporting AF 1. It was suggested to Victim Support by the Leicestershire and Rutland Safeguarding Board Officer that this may not be appropriate due to a potential conflict of interest and the case was reallocated to another worker.

2.4.6. The Panel were assured that a relationship between the Leicestershire and Rutland Safeguarding Partnerships Business Office and Victim Support was there to ensure that families who are affected by domestic homicide, and want support, receive this.

2.4.7. AM 1 advised the Overview Report Author that he had not been contacted and offered support since the Police Family Liaison Officer had ended her involvement with him but declined this when advised of what support was available to him. Sister 2 also declined the offer of support, preferring to utilise her current support network.

2.5. The Domestic Homicide Review Panel

2.5.1. The Chair of this review was Tracy Holliday**,** who qualified as a Social Worker in 1997, and at the time of this review was employed by Rutland County Council as the Safeguarding and Quality Assurance Service Manager / Local Authority Designated Officer. She had no recent/current or prior substantive involvement with the agencies involved in this review. The Partnership considered the appointment of Tracy Holliday to Chair this review in line with locally agreed protocols, and their decision was supported by her extensive experience in regard to domestic abuse and previous appointment as the Cambridgeshire County Domestic Abuse Coordinator, which involved strategic responsibilities and management of a specialist Independent Domestic Violence Service.

2.5.2. James Fox was brought in to chair the final stages of the review when the original chair was unable to continue. At that stage much of the analysis had been completed and James Fox's role was to oversee the effective running of the final DHR meetings and facilitate agreement of the final report. James Fox has been the manager of the Safeguarding Partnerships Business Office for Leicestershire & Rutland since 2016, managing the operation of the Safeguarding Adults Board and Safeguarding Children Partnership. The office is hosted by Leicestershire County Council but is independent of the council and all agencies involved in the review. He was previously employed as Community Safety Manager at Leicestershire County Council from 2008 to 2016. This role included overseeing the commissioning of domestic abuse support services and Domestic Homicide Reviews in Leicestershire and representing Leicestershire County Council on some of the local Community Safety Partnerships. This does overlap with part of the period covered by the review; however, during that time, James Fox had no role in the activity of any of the agencies or responses involved in the review.

2.5.3. Cherryl Henry-Leach was appointed as the Independent Overview Report Author. At the time of this appointment, she undertook this role as an Independent Practitioner, specialising in domestic and sexual abuse. She had not, at any point, been employed in the local area where the homicide occurred or been contracted to any of the agencies involved in this review. The Panel agreed that her prior experience (outlined in Appendix 1) evidenced her fulfilling the criteria set out in the statutory guidance for Domestic Homicide Reviews. She has completed the Home Office Domestic Homicide

Review training packages, including the additional modules on chairing reviews and producing overview reports. In addition, she has completed Home Office accredited training provided by Advocacy After Fatal Domestic Abuse (AAFDA) for Chairs and overview report authors.

2.5.4. In this activity, Cherryl Henry-Leach was supported by an associate, Peter Williams, who assisted her with research relevant to this review. The Panel were satisfied that Mr Williams's support of the Overview Report Author did not present any conflict in interest or compromise her independence in any way.

2.5.5. The Chair and Overview Report Author were supported by a Panel, the membership of which is as follows:

Chair	
Tracy Holliday (initial stages)	Safeguarding and Quality Assurance Service Manager and Local Authority Designated Officer, Rutland County Council
James Fox (latter stages)	Safeguarding Partnerships Business Office Manager, Leicestershire & Rutland Safeguarding Adults Board and Safeguarding Children Partnership
Independent Reviewer	
Cherryl Henry-Leach	Independent Overview Report Author
Peter Williams	Support to the Independent Overview Report Author
Panel	
Safeguarding Manager, Leicester, Leicestershire & Rutland (LLR) Clinical Commissioning Group (CCG) Hosted Safeguarding Team	
Service Manager, FreeVA (Free from Violence and Abuse) (representing UAVA [United Against Violence and Abuse])	
Head of Neighbourhood Services, Charnwood Borough Council	
Domestic Abuse Force Lead, Leicestershire Police	
Community Safety Coordinator, Leicestershire County Council	
Serious Crime Partnership Manager, Leicestershire Police	
Support to the Panel	
Board Officer, Leicestershire & Rutland Safeguarding Partnerships Business Office (SPBO)	

Administrative Assistant, Leicestershire & Rutland Safeguarding Partnership Business Office (SPBO)

2.5.6. In total, 5 Panel meetings were convened on 8th November 2018, 28th February 2019, 23rd July 2019, 11th October 2019 and 17th January 2020. At the inaugural Panel meeting, the Chair, with unanimous support from the Panel, decided to hold the review in abeyance until the outcome of the HM Coroner's inquest. The Home Office were advised of this decision and did not make any adverse representation to the Panel or the Community Safety Partnership in relation to this decision.

2.6. Methodology

2.6.1. On receipt of the death notification from Leicestershire Police, the Leicestershire & Rutland Safeguarding Partnerships Business Office approached the following eighteen agencies with a request that they review their records and advise on what involvement, if any, they had with either Adult 1 and Adult 2:

- Child Death Overview Panel (CDOP)
- Children & Family Court Advisory and Support Service (CAFCASS)
- Clinical Commissioning Group (CCG) – LLR Safeguarding Team
- GP Surgery 1, supported by the LLR CCG Safeguarding Team
- GP Surgery 2, supported by the LLR CCG Safeguarding Team
- Leicestershire Adult Social Care
- Leicestershire Children's Social Care
- Leicestershire Early Help
- Leicestershire Education
- Leicestershire Legal Services
- Leicestershire Partnership NHS Trust (LPT)
- Leicestershire Police
- Probation
- Rutland Adult Social Care
- Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP) (provider of Leicester, Leicestershire & Rutland Sexual Health Services)
- Turning Point (provider of Leicester, Leicestershire & Rutland Substance Misuse Services)
- United Against Violence and Abuse (UAVA) (provider of Leicester, Leicestershire & Rutland Domestic Abuse services), including
    - Free from Violence & Abuse (FreeVA)
    - Living Without Abuse (LWA)
    - Women's Aid Leicestershire Limited (WALL)
- University Hospitals of Leicester NHS Trust (UHL).

2.6.2. Of these, fifteen agencies confirmed they had no involvement with Adult 1 or Adult 2 prior to their deaths. Three agencies confirmed they had contact with Adult 1 or Adult 2 – GP Practice 1, Leicestershire Police and UHL. They submitted a summary of their involvement. Of these, the Panel agreed that the

involvement of UHL was in relation to medical issues pertaining to Adult 1 that were not relevant to this review or within its scoping period. The other 2 agencies were asked to submit Individual Management Review Reports.

2.6.3. It was noted by the Panel that GP Surgery 1 provided information in relation to Adult 1, and not Adult 2. Further clarification with the Clinical Commissioning Group confirmed that Adult 2 was also registered with this GP and they, subsequently, submitted a summary of their involvement with Adult 2. The IMR reports were quality assured through individual agency governance.

2.6.4. A number of interviews were also undertaken with family and friends of Adult 1 and Adult 2. This enabled further information to be gathered on behalf of the Panel, for their consideration against the Terms of Reference for this review. Adult 1 was in a new relationship at the time of her death. Her new partner initially agreed to contribute to the review, but later elected not to do so.

2.6.5. HM Coroner also enabled access to their files to support the review.

2.7. Equality and Diversity

2.7.1. Throughout this review, the Panel were mindful of and considered the nine protected characteristics[2] under the Equality Act 2010 (age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation). Adult 1 was female and Adult 2 was male. Both were White British and are believed to have identified themselves as heterosexual. At the time of the murder, Adult 1 was aged 42 and Adult 2 aged 45. Neither Adult 1 or Adult 2 had any known disabilities. Adult 1 and Adult 2 were married to each other. The Panel found no evidence that religion was a relevant factor in this case.

2.7.2. Sex was a characteristic in this case and warranted special consideration. Data shows that two women per week are murdered by their current or former partners in England and Wales[3]. Around three quarters of registered deaths by suicide[4] are males. Research also highlights that domestic abuse is a gendered crime, and the majority of victims of fatal domestic abuse are murdered by their current or former partners. There is empirical evidence to support the theory that men commit more acts of domestic abuse than women. Statistically, women are more likely to be victims of domestic abuse. In the year ending March 2019, an estimated 2.4 million adults aged 16 to 74 years experienced domestic abuse in the last year, of which 1.6 million were women and 786,000 were men. Women are more likely to be repeat victims of abuse and men are more likely to be repeat perpetrators.[5] The Panel fully acknowledge and understand the gender aspect in relation to domestic

[2] Protected characteristics | Equality and Human Rights Commission (equalityhumanrights.com)

[3] Home office - Domestic Homicide Reviews - KEY FINDINGS FROM ANALYSIS OF DOMESTIC HOMICIDE REVIEWS (publishing.service.gov.uk)

[4] Suicides in the UK - Office for National Statistics (ons.gov.uk)

[5] Walby et al, 2004, “Domestic violence, sexual assault and stalking: Findings from the British Crime Survey”.

homicide. Throughout this review, the review Panel focused on the murder of Adult 1 to establish the learning from this case.

2.8. Confidentiality

2.8.1. The findings of each Domestic Homicide Review commissioned by the Leicestershire and Rutland Safeguarding Partnership are “Official Sensitive” and information is only available to participating officers, professionals and their line managers with the approval of the Chair of a review. Once the review has been quality assured and accepted by the Home Office, the official sensitive delegation is lifted.

2.9. Dissemination

2.9.1. This report has been disseminated to the commissioning Community Safety Partnership and constituent representatives including the Police and Crime Commissioner (PCC).

3. Terms of Reference

3.1. Purpose of Domestic Homicide Review

3.1.1. The purpose of a Domestic Homicide Review (DHR) is to:

a. 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;

b. 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;

c. apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e. contribute to a better understanding of the nature of domestic violence and abuse; and

f. highlight good practice.

3.2. Timescales for this Review

3.2.1. The Panel noted that Adult 1 and Adult 2’s relationship spanned some 24 years in total, during which time responses to domestic abuse have undergone significant changes. To ensure a thorough but proportionate review, the Panel agreed the scoping period for this review would begin on 1st

April 2013, when the national change in definition[6] prompted focus on domestic abuse (rather than singular incidents of domestic violence), and end on the date of the deaths.

3.2.2. During the course of the review, some learning emerged in relation to support from families impacted by domestic homicides. The Panel agreed this would be reflected in the report where appropriate and extended the scope of this review. Agencies contributing to the review were subsequently asked to focus their involvement during the scoping period of 1st April 2013 to two weeks after the date of the deaths.

3.3. Case Specific Terms of Reference

3.3.1. The Panel also agreed the following case specific terms to ensure focused key lines of enquiry relevant to this review:

I. To review if practitioners involved with the family were knowledgeable about potential indicators of domestic violence and/or abuse, including coercive control, and aware of how to act on concerns/indicators about domestic violence and/or abuse to ensure early intervention and support

II. To determine if appropriate consideration to accessibility to support was given by agencies involved with the family when making decisions in terms of the level and support provided to members of the family, including the family's capacity to understand those decisions and how they could respond to those decisions

III. To establish if there were any opportunities for professionals to "routinely enquire" if domestic abuse, including coercive control, was being experienced by the victim that were missed, and if those enquiries would have recognised the victim's need for appropriate support, in line with national best practice

IV. To explore if there was appropriate information sharing between agencies in relation to any family members, including if any agency or professionals consider any concerns they may have raised were not taken seriously or acted upon by others and how information sharing can be improved to safeguard families impacted by domestic abuse

V. To establish how professionals carried out assessments, including whether:

- assessments and management plans in relation to any family member took account of any relevant history
- The history of domestic abuse was fully considered alongside an evidence led approach set out in the Criminal Justice Act 2003 to support gathering evidence of coercive and controlling behaviour (contrary to S76 of the Serious Crime Act 2015).

[6] https://www.gov.uk/government/news/new-definition-of-domestic-violence

Were the principles of positive action applied and/or the statutory guidance for the offence of coercive control considered in responses?

- If any contacts with any family could have afforded opportunities to assess risk and/or identify any warning signs of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals, including the use of markers/warnings indicators within agency systems

VI. To identify whether the Leicestershire and Rutland Safeguarding Partnership/Community Safety Partnership needs to consider any learning that would require further strategic review and/or analysis to inform tactical and operational responses when supporting victims or identifying/appropriately challenging perpetrators of domestic abuse within the local community

VII. To identify learning in relation to community awareness, including how community and/or faith groups and other potential access points are supported to identify safeguarding issues and/or victims of domestic abuse and share concerns with professionals, including if pathways for community and/or faith groups require development

VIII. To review the appropriate use of legislation and relevant statutory guidance pertinent to the family's situation

IX. To consider how issues of diversity and equality were considered in assessing and providing services to the family's protected characteristics under the Equality Act 2010 – age, disability, race, religion or belief, sex, gender reassignment, pregnancy and maternity, marriage or civil partnerships. This will include consideration of how agency awareness and understanding of relevant cultural, race, religious or nationality issues, and consideration of equality duties, impacted on responses and interventions

X. To establish whether local safeguarding procedures were properly being followed and how effectively local agencies and professionals worked together in relation to domestic abuse

XI. To establish if there are any relevant issues affecting public confidence in the protection of people in vulnerable situations, locally

XII. To establish what relevant policies, protocols and procedures (including risk assessment tools) were in place during the period of review, if these were applied and whether current training and policies support professional identification of coercive controlling behaviour

XIII. To identify any good practice and changes that may have already taken place

XIV. Establish for consideration what may need to change locally and/or nationally to prevent serious harm to victims of domestic abuse in similar circumstances.

4. Adult 1 and Adult 2

Due to the minimal agency involvement with members of this family, family and friends of Adult 2 and Adult 1 have supported the Panel by sharing their recollections of the couple, as individuals and also their relationship dynamic.

4.1. Adult 1

4.1.1. Adult 1 was the youngest of three sisters. Sisters 1 and 2 both described her as a very "thoughtful and helpful person who liked caring for children" who enjoyed a "close relationship with our nan". They recalled an unhappy childhood that resulted in their mother leaving the family home "when Adult 1 was very young". Adult 1 met AF 1's biological father, and shortly afterward became pregnant with AF 1 at the age of 18. Sister 1 said that her relationship with AF 1's father broke down after Adult 1 became pregnant and Adult 1 decided to be a single parent. It was confirmed that Adult 1 lived in rented accommodation with AF 1 until they went to live with Adult 2.

4.1.2. Sister 2 explained that, as the sisters became adults, she and Adult 1 remained in touch "but not close…she never forgot a birthday and would always spoil my children…but she seemed more into her friends than her family, she was really into football and they were…We both had busy lives, I guess we just drifted apart, and because we had different groups of friends we didn't socialise that much". Sister 1 said that she had a closer relationship with Adult 1 but described in detail how this closeness ended 2 years before the deaths (this is referred to below). Shortly before she died, Sister 1 described that "Adult 1 turned up at my house, it was just after our nan had died. We thrashed out our differences and realised it was all down to his behaviour…I missed her friendship but would never have knocked on his door to see her. So, I didn't know she had moved out until after [she died]".

4.1.3. AF 1 and friends of Adult 1 all described her with warm fondness and regard. In each of the interviews, she was referred to as a warm and loving person whose generosity was well known and that her caring nature often meant she would "put others before herself". AF 1 recalled that "my mum could be stubborn and fiery at times, particularly if she thought she was in the right". AF 1 also recalled that "mum had a very close circle of friends – she had lots of mates through football, but only a few close friends that she spoke to". All recalled that "Adult 1 liked to shop".

4.1.4. Friend 3, who had known Adult 1 for 19 years and been very close to her for the past 17 years, described Adult 1 as "good friend" who "enjoyed shopping for clothes and handbags – she always wanted to be sure she looked her very best when we went out." Sister 1 also recalled that "Adult 1 liked her shoes and handbags, but she always bought expensive gifts for AF 1 and Adult 2". Adult 1 is remembered as "being really into football" with a likeminded circle of friends. Friend 3 said that Adult 1 was "definitely a big part of the group because she would do anything for you, she was generous and kind and

willingly look after the kids for example, when we were on holiday…if she was comfortable in something she was alright but could be reluctant to try something new…She could be shy in other respects, and did not have a lot of self-confidence". Both Friend 3 and Sister 1 both said that Adult 1 "was not sensible with money". Sister 1 said that "when she got with Adult 2 she had catalogue debt and no credit history", and Friend 3 said that in the later years of her relationship with Adult 2, Adult 1 was in debt "because of her spending mainly…she could be quite impulsive with her spending". Friend 3 also said that she was aware that Adult 1 elected to share different issues with different people: "I was the sensible one about money and she went to others for advice on different things".

4.1.5. Friend 3 also said that Adult 1 "kept herself fit" and others also recalled that she enjoyed "jogging, cycling" and partying.

4.1.6. Adult 1 is remembered as working for a local solicitor for a number of years. Sister 1 explained that she job shared with Adult 1 and, when Sister 1 left the firm, Adult 1 increased her working hours, stating that "she felt she could because AF 1 was older". In the final year of her life, Adult 1 began working for a local airport. AF 1 recalled that "mum really enjoyed that job"; Friend 1 said that when Adult 1 "got the job at the airport it was like she had turned a corner and was really happy". Friend 3 also recalled that Adult 1 "getting that job was definitely a good thing and she was happier". Adult 1 also undertook community work, volunteering for a number of years as a Girl Guides worker. AF 1 recalls that "after mum died, they sent her a tribute around, planting seeds and sunflowers to remember her…it was a nice way to remember mum."

4.1.7. AF 1 described having a very "close and strong" relationship with Adult 1 and described Adult 1 as "the best mum ever…very generous and loving…when it came to Christmas and birthdays she would always go the extra mile…with extra surprises…I couldn't have wished for a better mum". She also recalled that Adult 1 worked part time "when I was little, so we would spend as much time as we could together, doing girlie things. She spoiled me. When I went to school, when I came home, she would always have a present for me…she liked me to do well at school and was so proud when she saw me graduate…Mum liked her holidays…me and her went to Tenerife a couple of years ago and she always said that was the best holiday she ever had…".

4.1.8. AM 1 states that he had minimal contact with Adult 1. He described having a strained relationship with Adult 1, whom he found to be "distant …if we saw each other in the street she would put her head down and walk past me". Friend 4 also recalled that Adult 1 could be distant and would not engage in any level of conversation beyond civilities.

4.1.9. Despite these two differing viewpoints, Adult 1's family members and friends all remember Adult 1 as someone who "cared for others before herself…she would help anyone, even if she didn't know you, if you needed help, she would help you". AF 1 says that "I used to depend on my mum for everything, and now she's not here I am having to do things for myself. I like to think that she would be really proud of me…the thing I miss most about mum is her not

being there…we used to talk about little things, like my day and stuff like that. At the time, unimportant things, but I miss that the most now she isn't here…".

4.1.10. It was established by the Police, as part of the Coronial investigation, that Adult 1 did not keep a diary or journal, but she did use her mobile phones to catalogue her injuries and also record some of the discussions she had with Adult 2 about his abuse of her. Why she did this or on whose advice could not be established by the Police or the Panel.

4.2. Adult 2

4.2.1. It was evident from the discussions that many who knew the couple were struggling with Adult 2's culpability for Adult 1's murder. Many said that Adult 2 could be, as AM 1 said, "someone who would do anything to help you if you needed it, so it is really hard to see him as being cruel enough to kill someone". AM 1 said that "I know he did a bad thing in the end, and no-one can ever fully understand why he did…so I want to remember Adult 2 as an outstanding young man, intelligent, who loved football and cared for people".

4.2.2. Friends 1 and 2 also recalled that Adult 2 was particularly supportive of them when they experienced an unexpected bereavement. Friend 4 also described Adult 2 as "good friend to me". Friends 1 and 2 also noted that, since the murder of Adult 1, they had realised that "you never know what really goes on between and a man and his wife…it makes me wonder what she was living with and if we could have done more. We always thought he was a bit odd, tight with his money, but we never thought that he was abusive to her…we did not see anything like that…Looking back now, I can see that when we thought she was being unkind to him, she was probably feeling safe enough to retaliate. I am so sad to think what he must have been putting her through and my friend was killed by someone she trusted…we knew she was unhappy, but we didn't really know why, did we?" Friend 3 also described observing Adult 1 challenge Adult 2 about his behaviour and said that "we have wondered if she did this because she felt safe to do so because we were around… He was a quiet person who didn't say a lot in company. There were times when you could just tell something had been going on – silences between them. But she never showed me any bruises or injuries."

4.2.3. Adult 2 was an only child. AM 1 recalled that Adult 2 was popular when younger, and had a lot of mates, some of whom he stayed friendly with because they were "into football like he was". AM 1 also said Adult 2 was intelligent and had "a very close relationship to his mother, loved her to bits. He took his mum's death quite hard, but he didn't like to talk about his feelings". AM 1 said that he would try to enable Adult 2 to open up about the loss of his mother, but Adult 2 would "change the conversation".

4.2.4. AM 1 stated that he had always enjoyed a close relationship with Adult 2, but that he saw less of Adult 2 after his relationship with Adult 1 began. AM 1 also said there was a caring aspect to Adult 2's behaviour: "He was always thinking of my health. He was also safety conscious. He would say lock that door…you don't know who's about. He kept things close to his chest, bottled it up but he would help you when you needed it."

4.2.5. AF 1 was clear that, although Adult 2 was not her biological father, he was supportive of her having contact with her biological father and “didn’t mind me talking about [my biological father]”. In the interview, AF 1 described how Adult 2 would “do things [with me] that you would do as a dad, like taking me out shopping or out for the day”, and that he “treated me as his own”. AF 1 recalled that Adult 1 wished for AF 1 to refer to Adult 2 as “dad” but said that “I decided not to as I knew my real dad and I didn’t think it was right, so I called him Adult 2”.

4.2.6. AF 1 also recalled that Adult 2 frequently demonstrated controlling aspects of behaviour: “he would have to open and close the curtains, no one else was allowed to touch them, and he would get mad if you did. Placemats on the table had to be in the right place next to each other on the table. TV remote controls had to be in their proper place. He had to lock the door whenever we went out, this was like a routine. We couldn’t just leave the house; he had to do this and check three-or four-times sometimes”. Friend 3 also recalled that Adult 2 was well known for “being obsessed with keeping his house tidy, and we never went to their house for parties and such like, because we knew, used to joke, that if we did, Adult 2 would spend all the time cleaning up around us”. Friend 3 also said that, on the occasions she visited the couple’s home, Adult 2 “would be cleaning around you in his house, and it would make you so uncomfy you would leave”.

4.2.7. Friend 4 stated that he met Adult 2 at work. They were colleagues but also became friends with shared interests that included football and cycling. Their friendship spanned some 20 years, during which time he recalled Adult 2 having a “wide circle of friends”, and that Adult 2 was “often late for things, careful with money, a clever bloke. I couldn’t understand why he was so tight, he had money, more money than me, a good car, nice home, decent job…was a good lad, never knew him to lose his temper with anyone, very friendly with all…but he could be tight with money, I always had to push him to get a round in…”. Friends 1 and 2 also described Adult 2 as “having a mean streak in him in that he never wanted to put his hand in his pocket and buy a round”. AM 1 disagreed that Adult 2 was frugal stating that “he gave [Adult 1] the world…but you can’t buy a relationship although he just would not accept that”.

4.2.8. In the months preceding the deaths, Adult 2 was advised that he and many other of his colleagues were “at risk” of redundancy.

4.3. The Couple’s Relationship and Significant Events Prior to the Deaths

4.3.1. The Police Family Liaison Officer helpfully provided a conduit for the Overview Report Author to interview family and friends who had given statements to the Police during the murder investigation. Some of Adult 1’s friends elected not be included, and this included her new partner. The interviews that were undertaken identified the following themes:

- Family and friends could not confirm, definitively, when the couple met, or when they became known as a couple to friends and family. AF1, Sister 1 and Sister 2 all agree that it would have been when AF 1 was very young. When AF 1 was aged 3-4 years old, Adult 1 was asked by Adult 2 to live with him.

- Adult 1 and Adult 2 appeared outwardly happy for the first few years of their relationship of 24 years.
- They had a circle of friends with whom they socialised and holidayed with. Some shared the couple's passion for football and this group of friends would frequently meet to socialise before football matches, and go together to watch away matches.
- When the couple decided to live together, they purchased a property from AM 1 at a price that was less than the market value.
- Adult 2 refused to put Adult 1's name on the deeds and ensured that he paid all of the bills.
- The couple's finances were kept separate, and this appears to have been at Adult 2's insistence. Although Adult 2 earned more than Adult 1, this included Adult 2's insistence that Adult 1 pay half of any additional expenditure (e.g., holidays and socialising).
- Adult 2 was known to be overly frugal and reluctant to spend money. This embarrassed Adult 1 when the couple socialised, and she would give him money to prevent further embarrassment (e.g., to buy drinks).
- Adult 2's behaviour began to result in Adult 1 isolating herself from others when she sensed others felt uncomfortable because of it.
- During the course of her relationship with Adult 2, Adult 1 had confided in AF 1, Sister 1, Friends 1 and 3 that she was a victim of domestic abuse perpetrated by Adult 2.
- AM 1 believed that any abuse she experienced was the result of her goading Adult 2 "over the edge".
- Other friends did not know that domestic abuse was a feature, but those closer to Adult 1 than Adult 2 suspected he was violent toward her.
- All recounted instances where the couple argued in public when Adult 2 tried to control Adult 1 or when Adult 1 made fun of him. This gave the outward appearance that this was a volatile relationship. However, Adult 1 disclosed to others that Adult 2 would be abusive to her when others were not around and that he would cause injuries to her person that were not visible and easily hidden.
- Occasionally, Adult 2's behaviour toward Adult 1 resulted in others intervening and challenging him about his treatment of her. Adult 2 would respond that they did not know how Adult 1 was when others were not around.
- There was an aspect of Adult 2's character that was controlling. This manifested to others as idiosyncrasies, odd behaviour or being obsessive about what are described as "petty things".

- There was collective surprise the couple decided to marry due to the difficulties they were aware the couple experienced.

- After the marriage, there were indicators that Adult 2 had become possessive of Adult 1, and aspects of controlling behaviour extended to the couple's sleeping arrangements and shopping arrangements. He also began to show displeasure when Adult 1 socialised without him.

- Financial issues were a feature for the couple. Some were aware of this but not the extent of the couple's debts.

- AM 1 and Adult 2's friends had a perception that Adult 2 was financially secure, and he was frequently described as "never being short of money". However, his employer confirmed that Adult 2's annual income was in the region of £35,000. There were no opportunities for Adult 2 to enhance his income, for example, by working additional hours and there was no evidence to suggest he had any other form of income.

- During the last 3 years of their relationship, friends and family described their increased awareness, from what Adult 1 told them but also their observations, of the couple's relationship dynamic, and that the violence within it began to escalate.

- Adult 1 wanted to leave Adult 2 but was worried about how the loss of family would impact on AF 1 and she was reluctant to access support about domestic abuse and accommodation from agencies described as "charities".

- When friends suggested support was a viable option to either Adult 1 or Adult 2, there was a lack of awareness in terms of what the support was, or how it could be accessed.

- There was a collective view that only Adult 1 could access support from the Police, and she was reluctant to do this, apart from occasions where she was described by AF 1 as being "terrified" of Adult 2. Otherwise, Adult 1 would manage her safety by creating distance from Adult 2, e.g., sleeping with AF 1.

- In the last year of the relationship, Adult 1 had decided to end the relationship.

- At some point in the last year of their lives, Adult 2 was made aware that he and other colleagues were to be "at risk" of redundancy. Adult 2 was not anxious about this as he understood another role would be secured after his employers restructured.

- In the October before the deaths, the couple re-mortgaged the family home. The proceeds were used to clear Adult 1's credit card debt.

- Adult 1 secured alternative employment that she enjoyed.

- Adult 1 decided to leave Adult 2 after she began a new relationship with a mutual acquaintance.

- Adult 1 appeared much happier in herself and her new life.

- Shortly after the separation, she began to disclose to AF 1 and Friend 1 that Adult 2's behaviour (namely him hiding in the house and sneaking up on her) was scaring her.

- Adult 1 also shared with Friend 1 that Adult 2 appeared to be following her and others also witnessed this.

- Adult 1's new partner supported her to be less dependent on Adult 2 by providing Adult 1 with a car, so she could be mobile without car sharing with Adult 2.

- Although Adult 2 struggled to accept the relationship was over after Adult 1 left him, in the days preceding the deaths he appeared to AF 1, Friend 1 and Friend 2 to be more accepting of their separation and did not give any indication that he planned to kill Adult 1 or take his own life.

- On the morning of the day of the deaths, Adult 2 was interviewed for an alternative role within the company that employed him. He is described by his employer as being calm, forward thinking and affable in interview, and left the site afterwards. Although Adult 2 would not have known the outcome of this interview, he is likely to have known that no other colleague was being considered for the role.

- On the day of the deaths, AF 1 confirmed that Adult 1 returned to the family home to collect some belongings. She would not be aware that Adult 2 had an interview that day and so would also be at the family home.

- The bodies were found by AF 1. AF 1 also found a note left by Adult 2 and shared that the content of this still angers her.

4.3.2. AF 1 described how Adult 2 and Adult 1 met through a mutual friend that knew AF 1's biological father. Adult 1 and Adult 2 had a close circle of friends who shared a similar interest in football. This formed the basis of their social life and the friendships that ensued, with frequent trips, holidays and parties being a feature of their lives.

4.3.3. AF 1 recalls she was a toddler when the couple met, and Sister 1 recalls that Adult 1 was "infatuated with Adult 2 from the off…after they got together, initially, he showered her with stuff and that never sat right with me". Sister 1 described feeling "unsure of Adult 2 from the start of their relationship". Sister 2 recalled that because "Adult 1 chose him I accepted it, but I couldn't really say I liked him…I just thought there was something about him that was odd…the first time I met him his arm was in plaster, I didn't known him but he seemed keen to tell me that they had locked themselves out of her house and he had put his fist through the glass to get in the house. It was an odd explanation and one I did not invite…Trying to put my finger on why I thought he was odd is difficult. He didn't seem to share or engage with people like others did…I could see there were good things about him, like he was nice to our nan. He would take her dinner on a Saturday, Adult 1 used to do this, but he seemed to take over a lot of things like this and other tasks, little things like dropping off cards and presents that meant we didn't see Adult 1 as often…".

4.3.4. A similar reflection was shared by Sister 1: “before she met him Adult 1 never missed a birthday and would always make sure she brought our cards or kids’ birthday present over the day before. A couple of years after they got together, I noticed that Adult 2 was the one that had taken this over – it was him who dropped off the cards and presents, not Adult 1. Initially this was odd, but we just got used to it because she had her own life by then, with their friends”.

4.3.5. Sister 2 also recalled a barbeque that took place at the couple’s home shortly after they moved in: “I recall that we were chatting with Adult 1 in the kitchen and Adult 2 came in. He called Adult 1 a name that I found a little offensive and I felt uncomfortable. Adult 1 said it was a joke name, but he just stood there. His continued presence made me feel unwelcome, like I was intruding…I remember that one of the last times I went to his house was just before AF 1’s birthday, when we dropped off the birthday present. We knocked for ages, but nobody answered, but his car was on the drive, so I knew he was in the house. I even saw him look through the spare bedroom window at us. He just stood there looking at us. In the end, we left the present on the front doorstep, and I messaged AF 1 with the location of the present. Adult 1 got back to us later to say he was in the shower and hadn’t heard us knock – but he had. It was just very odd.”

4.3.6. AF 1 states that she was about 4 years old when the couple began to live together. AM 1 stated that he decided to sell the couple his home because “I was looking to downsize at the time, and it made sense that. If I could help them to buy it, they’d have somewhere to live that was big enough for a family”. It is understood that AM 1 did not charge the couple the full market value for the property in an attempt to support their new life together. Sister 1 said that the solicitors where she and Adult 1 worked dealt with the conveyancing, and the department she worked in meant that she had an insight that others may not, and that there were indications that Adult 2 did not want Adult 1 to have a claim on the property should they separate in the future. She said that, with hindsight, she can now see that issues were already evident in the relationship because Adult 2’s instructions to the conveyancer were:

- Adult 1 was not to be named on any of the documents in relation to the property.
- All of the correspondence regarding the purchase was to be addressed to Adult 2 and, on one occasion, when an administrative error resulted in a letter being addressed to both Adult 2 and Adult 1, he was absolutely fuming and complained.
- All of the utility bills were to be in his name and Adult 1 would not contribute.
- There was no joint bank account, so his earnings were kept separate to Adult 1’s.

4.3.7. Both Sisters recalled visiting Adult 1 once the couple had moved into the property. Sister 1 said that she and Adult 1 would “joke about Adult 2’s OCD – how he had to have cushions a certain way, so they were just so, and the

curtains straight". They described being "made to feel unwelcome by Adult 2, who was always around, tidying up, but it meant we couldn't speak to Adult 1 on her own".

4.3.8. Both Sisters recalled seeing a duvet rolled up in the corner of the living room. They were unable to question this with Adult 1 in the couple's home but used a family barbeque as an opportunity to discuss this with her. Both said that Adult 1 told them that "Adult 2 wouldn't let her sleep in bed with him because they were not legally married, and he didn't want her to have a hold on his money because it was his property." Sister 2 recalled that Adult 1 did not see this as an issue or unusual and seemed accepting of the situation.

4.3.9. Initially, AF 1 recalls, that "things were really happy when we moved in [with Adult 2], and we were a family". Others who knew the couple at this time also recalled the couple appearing to be happy when they socialised. Others also recalled how Adult 1 would frequently be embarrassed by Adult 2 not "paying his way, for example, he'd always be the last one to get a round in, and then I had to push him" recalled Friend 4. Over time, this caused Adult 1 increased embarrassment, particularly when the couple holidayed with others.

4.3.10. Friend 1 described how, in the early years of their relationship, there were no apparent concerns about the couple's dynamic other than Adult 2 continuing to buy his own food, and Adult 1 buying food for her and AF 1. In time, it became widely known in the social network that Adult 1 would purchase food for herself and AF 1 to prevent what are described by Friend 1 as "petty arguments that erupted over him controlling household purchases, things like that".

4.3.11. Friend 1 also described some behaviours of Adult 2 as being perceived as odd at the time, but, since the murder of Adult 1, she now recognised they were controlling. For example, when "we went out for a meal, he would control where Adult 1 sat...". Friend 1 said "They had a bit of a strange relationship…his money was his – you pay this, and I'll pay that. He had a good car, cheap house, season tickets but he wouldn't spend money on Adult 1 and AF 1". Friend 3 also said that "it was strange to me that everything to do with money was separate. Sister 1 also recalled that when the couple went out for meals with her and her husband, "Adult 2 would always order the cheapest thing on the menu and that Adult 1 would say he was doing this to wind her up…this would cause an argument in front of everyone…She also told me that she had to buy food for her, and AF 1 and he bought his own". It was during this period in time that Friend 1 also noticed he "always had to be the one to lock the door, do things like that, we thought he had OCD, but I started to see him being mean with his money".

4.3.12. Friends 1 and 2 described how they tried to support Adult 2 to recognise that "some of things he was doing wasn't right, but he would tell us that we didn't know what [Adult 1] was really like without elaborating any further. I remember my daughter seeing something and telling me not to trust anything he said about Adult 1. Then Adult 1 told us that Adult 2 would be quiet and moody when she joked about his ways. This was always when we were out with them. Looking back now I wonder if this was when she felt safe to say

something because she would tell us then that Adult 2 got nasty when he'd had a drink, but not until he'd got back to the house. So, we stopped [challenging him about his behaviour] we didn't want to make it worse for her."

4.3.13. AF 1 stated that "family life was really happy until I was about 8 or 10". By this time, she recalled that "Mum and Adult 2 were arguing a lot and I was often sent to my room when this happened…but I would be upstairs listening…not being able to see what was going on was very distressing." AF 1 described how, as she became older, she observed Adult 2 pushing Adult 1 during arguments that AF 1 says were, by this time, common events. She recalled that sometimes Adult 1 would push him back "to create some space from him or in what I would call self-defense, but mainly she would move away from him".

4.3.14. It was around this period that Sister 1 also recalled Adult 1 telling her that Adult 2 had a propensity to be violent toward her: "I would ask her why, and she would say because he was stressed at work. I'd tell her this wasn't right, and she needed to leave him. I never saw him hit her, but I did notice she seemed to be taking a lot of paracetamol, constantly". Friend 3 also said that it was about this time that Adult 1 first disclosed that Adult 2 was physically abusive toward her but said that by this time "I knew things weren't right between them because I'd seen them have arguments over things that seemed petty to me, but where usually when she was telling him to stop being silly fussy or mean."

4.3.15. All who knew the couple and contributed to the review expressed surprise that the couple decided to marry. Sister 1 said that "they got engaged years ago, and he was reluctant to get married. I think this was because he didn't want Adult 1 to have a penny from the house. Then she stopped wearing her ring, and a few weeks later had got it back and she was excited about getting married. I believe that she gave him an ultimatum and he agreed to marry her". Sister 1 and AF 1 both shared that they now believe, with hindsight, that Adult 1 naively thought marrying Adult 2 would improve her relationship with him. AF 1 also said that "mum knew that if things didn't work out, she would have one day filled with happy memories with him to look back on". Sister 1 also agreed that Adult 1 desired the wedding day rather than the marriage so that "she would have something nice, one lovely day, to remember about the relationship".

4.3.16. Friends 1 and 2 said that they lived in close proximity to the couple's home, and were aware that, "just after they got back from honeymoon", the couple would have volatile arguments which were discussed between neighbours who overheard them. They both recalled an occasion when AF 1, who was about 12 years of age at the time, entered their home and asked Friends 1 and 2 to help "calm Mum and Adult 2 down". Friends 1 and 2 described entering the couple's home and finding "everything of value smashed up, the whole house was wrecked". Friend 1 said she asked Adult 1 what had happened, and Adult 1 told her that Adult 2 had attacked her and she "had stabbed him with a pair of scissors in self-defense; her arms and face were badly bruised". Adult 2 had a superficial cut to his arm which Friend 1 cleaned and dressed. Neither Adult 2 or Adult 1 would access medical treatment for

their respective injuries, nor would they speak with the Police. Shortly after this Friend 2 recalled that on one occasion he “stepped in because Adult 2 was having a real [verbal] go at Adult 1 and someone had to tell him to stop”. A few weeks later, Friend 1 says that Adult 1 confided in her, saying that Adult 2

- was still hitting her, but “in places on the body where you couldn’t see it under the clothes.”
- Wouldn’t let her sleep in their bed, “particularly when she had gone out with her friends, and he wasn’t happy”.
- Adult 2 would move her things around the house or hide them, so she couldn’t find them which Friend 1 said was confusing and distressing Adult 1. By way of example, Friend 1 recalled loaning Adult 1 an expensive piece of jewellery that went missing. “When Adult 1 couldn’t find it…she was mortified because it wasn’t hers and was expensive. Adult 2 denied seeing it. I told her it would turn up. It wasn’t until after she died that it did – at the very back of a cupboard in the spare room – his room, somewhere where she wouldn’t have thought to look.”
- “On another occasion, I was helping her to clean up their house after another bad fight, and we found her wedding dress had been taken out of its box and scrunched up at the back of wardrobe in his room, it was in an awful state and meant she couldn’t sell it on. She was so upset. But he denied having anything to do with it…”

4.3.17. Friend 1 says she asked Adult 1 to report this to the Police and that she also told Adult 1 that there was support for her if she wanted to leave Adult 2. Friend 1 asked Adult 1 if she wanted Friend 2 to speak to Adult 2 about the abuse she was experiencing but Adult 1 declined, saying she was worried that if they “split up, Adult 2 would have no-one to support him". Adult 1 also advised Friend 2, that “she couldn’t leave Adult 2 and start again from nothing…and she said she was trapped because of the debt.” When asked what support she thought was available to Adult 1, Friend 1 stated “I know there are charities that can help but I would have to google them for her”.

4.3.18. Friends 1 and 2 also described seeing a subtle change in the relationship around this time: “there wasn’t any open warmness between them, and he was even more controlling with money, had become lazy around the house and possessive of Adult 1…he saw her as his possession – he owned her”. AF 1 also recalled that “Adult 2 didn’t like mum going out with her friends, even though that didn’t stop her…on at least one occasion he went looking for her when he didn’t know where she was. He wanted to go out with her when she went out with her friends…when she returned, he would find an excuse to argue and have a go at her. She would go out once every 2– 3 months…Adult 2 was also possessive of property and things belonging to him, like his clothes. He was very possessive of mum…he would pick her up from the solicitors…sometimes waiting for her to finish for up to 2 hours, sitting outside in the car.”

4.3.19. Sister 1 also recalled Adult 2 collecting Adult 1 from work and waiting for her to finish work and said that “sometimes we had to work late to make sure cases were completed…he would come for her at the normal time, and she would tell him she had to work late. He would sit in the car and wait for her, sometimes for ages. On a couple of occasions, she didn’t have to stay behind, but would find things to do, and I wondered why she wouldn’t want to go home, why she would prefer to be at work.”

4.3.20. AF 1 also said that in the later years of the relationship “Adult 2 would do a food shop just for himself, brands that he preferred and would always choose items that had a number of packets in for his working week, like crisps and bars, so we knew that we had to replace them if we ate them…which we rarely did because they were his.”

4.3.21. AF 1 said that her mother had a falling out with her sisters and was “told at the time, by mum, it was a silly argument with [Sister 1] over a birthday card.” Sister 1 confirmed that she had a falling out with Adult 1 because Adult 1 would repeatedly make excuses for Adult 2’s behaviour which Sister 1 felt, at times, was unkind to Sister 1 and was, Sister 1 believes, intended to undermine their relationship.

4.3.22. AM 1 advised that he suspected the couple “sometimes overspent” and that he loaned Adult 2 money after a family holiday as “they’d overspent on holiday, but I thought who doesn’t? I never thought for one-minute things were as bad [financially], but the holidays had to be paid for somehow, didn’t they?”.

4.3.23. AF 1 recalls that in “the October before mum died, our home was re-mortgaged, and I learned later this had happened a few times. For some reason, this time Adult 2 was willing to pay off my mum’s credit card debt, and I think he paid between £10-14 000. I knew they both had credit cards, but I didn’t know the extent of their debts”.

4.3.24. Friends of the couple were also aware of the couple accruing debts prior to Adult 1’s murder but expressed surprise at the full amount that only became apparent after Adult 1’s murder. Friend 4 stated that he was surprised that Adult 2 “was in debt, given he seemed to be so careful with money”.

4.3.25. Friend 1 advised that she was aware of Adult 2 clearing Adult 1’s credit card debt, as both Adult 2 and Adult 1 had disclosed this to her separately at the time. Friend 1 said that Adult 2 had told her this would mean Adult 1 would stay with him and says she “assumed that he meant Adult 1 would feel indebted, beholden to him and so would stay with him”. However, Adult 1 disclosed to Friend 1 that “Adult 2 clearing these debts meant that she was free from him financially and could begin to plan a future without Adult 2”. After the deaths, the extent of the financial difficulties the couple were experiencing, with debts over £40,000 in addition to an increased mortgage, became apparent to AF 1 and AM 1 and was a surprise to them.

4.3.26. AF 1 recalled that, in the 2-3 years before the deaths, Adult 1 “began to be more open with me about what Adult 2 was doing to her. I started to see more of the cuts and bruises that Adult 2 had caused…”

4.3.27. Friend 3 said that the couple's relationship "gradually went down-hill after they married, but particularly so in the 18 months before the end. I think that she had resolved to leave Adult 2 by then, but she wavered…I think she struggled because of AF 1, and she stayed with Adult 2 longer than she should have because of AF 1, whom Adult 1 wanted to have a family. I did suggest to her that there were charities that could help but she was proud like that and would not seek help, and she struggled with ending things because she didn't want AF 1 to know what it was like to have nothing." When asked which charities she was referring to Friend 1 said she couldn't be specific, and she would have needed to look them up.

4.3.28. AF 1 also recalled that the violence in the family home significantly escalated during this timeframe: "there were nights when mum was so scared by Adult 2's behaviour she would sleep in my room. There were also nights where he would shut their bedroom door on her and hold it shut, I'd hear her trying to get in [their room]…I used to tell her she could do better than Adult 2…I know she stayed with him longer than she should have, and I know deep down she wanted to give me stability…". Friend 1 also said, that as AF 1 got older and met her partner, AM 2, she was aware that AM 2 had refused to stay over at the family home "because one night when he was staying over Adult 2 was pacing round the house and jumping on the bed being really strange. Adult 1 was so frightened she slept with AF 1 and AM 2 that night. It left AM 2 shaken, really scared, and so he didn't stop there much after. This meant AF 1 stayed over more at his place." This was confirmed by AM 2, who said incidents like this occurred frequently, and there was an ever-present tension between Adult 1 and Adult 2. AF 1 also confirmed that incidents like this occurred frequently "but usually when he'd been drinking. He drank red wine almost every night in the house, something he'd always done since I was little, then on the weekends he drank more heavily with his friends."

4.3.29. Although AM 2 also confirmed these incidents occurred when Adult 2 had been drinking alcohol, but he also noted they "only ever occurred when Adult 1 was in the house". When Adult 1 wasn't in the house, AM 2 said Adult 2 would be "pleasant and friendly, how you'd expect him to be really", and Adult 1 would try to diffuse Adult 2, with little success and so manage her safety during those incidents by sleeping with AF 1 and AM 2. AM 2 did not recall the couple referring to the incidents after they occurred and said that Adult 2's behaviour, whilst "odd", did not "reach a point where I would have phoned the Police or intervened...but it did make me feel uncomfortable – it wasn't what I was used to and AF 1 liked coming to my family home, so that's what we did...I did worry about Adult 1 when we stopped staying at AF 1's house, but she always told us things were fine, that there was nothing to worry about...there wasn't anything to say to me that things were not fine...".

4.3.30. Friend 1 said that "toward the end [of their lives] they lived together but weren't together as a couple. She told me she'd asked Adult 2 to go for marriage guidance to work out their difficulties. Adult 2 didn't want to do that and kept telling her their relationship was normal. When the relationship was over [to her] and I told her she needed to tell Adult 2. Adult 1 was worried about how Adult 2 would react, but she seemed to be more worried that we

would stay friends with Adult 2 so that he had support – and that is how she was, always thinking of others before herself. We reassured her that he would remain our friend too…I had a long conversation with Adult 2 when we went away to watch the football, outside of a pub. I told him that the way he treated her wasn't normal, it wasn't a good relationship and he had to let her go because he wasn't treating her as you would in a normal relationship. I told him he could get help from somewhere if he needed it. I know Friend 2 also told him to move on and let her go. But all he would say to us was that he loved her. When they all got made redundant, Friend 2 spoke to him again and told him he needed to let her go, and that he needed to move on."

4.3.31. Friend 1 said that she was aware that Adult 1 had met someone else "in the Autumn before Adult 1's murder. He was part of the football crowd. She told me they'd become a bit chatty, and it went from there. She seemed really happy. I think she finally realised that she was attractive, and she wouldn't be lonely if she left Adult 2. Adult 2 had convinced her no-one else would want her, you see. She'd turned a corner, just started her new job and things were looking much brighter, she told me she felt she could leave Adult 2 because AF 1 was older and because he'd paid off her credit card debt." Friend 3 said that Adult 1 told her small circle of friends in the Autumn before her murder "that she was planning to leave Adult 2 and move in with [her new partner]. She definitely found it difficult to tell others, but she'd told me a while before he came on the scene that she had told Adult 2 it was over between them before she found anyone else. When she told us about him, she was worried we weren't going to be her friends anymore, but that would never have been the case."

4.3.32. Friend 1 also stated: "I know that when she met [*her new partner*], the relationship, as far as she was concerned, was dead. In the past, Adult 1 had gone to the Police when she was terrified by him a couple of times, but she told me that after she met [*her new partner*] she thought things were going to be better [for her]. Being free of her debts helped her to see she could move on, and I think Adult 2 could see she was moving on…but she also told me that Adult 2's behaviour [toward her] was getting worse, scarier…". Friend 1 advised this included Adult 1 telling her that Adult 2 would:

- Hide in the house and sneak up on Adult 1.
- Follow her when she went out with her friends and, after she moved in [with her new partner], the couple had seen Adult 2 in his car parked across from [her new partner's] flat".
- Unpack boxes, or take out small items that she would need, then denying that he had done so when she had filled the boxes with a view to taking them to her new home when Adult 2 enabled Adult 1's use of his car.

4.3.33. AF 1 states that "mum didn't tell me about [*her new partner*] until the New Year…but just before, that Christmas, I knew it was over because mum was willing to work Christmas Day and you could tell it was bad between them". When asked, AF 1 clarified that there was a "tension when they were both in the house". AF 1 also believes that AF 1's plans to purchase her own home

"prompted mum to go…after she left Adult 2 was depressed and constantly asking me when she would come back or if I had talked to her. Adult 2 said he still loved my mum and would do anything to get her back…but ultimately, I just wanted my mum to be happy. After the spilt, mum told me she had come to the house to collect some of her belongings when I was at work, and she thought Adult 2 was at work too. She used to walk through the front door, put her keys, sunglasses and handbag on the windowsill then take off her shoes – that was something she always did. She thought she was alone and took her shoes off, when she straightened back up, Adult 2 had popped up behind her out of nowhere. It terrorised her. Another time she came in through the front door and he was behind her out of nowhere. When she told me about it, I thought it was odd because the kitchen door was closed." AF 1 explained the kitchen door being shut was unusual the kitchen door was routinely kept open. She went on to explain that Adult 1 had placed a camera on the kitchen side pointed into the hallway because there had been some burglaries in the area some years ago. "It didn't work properly, but we didn't think Adult 2 knew that, because mum always kept the door open so that if anyone broke in again they would see the camera from the hallway". AF 1 says, "him closing the kitchen door is the incident that convinces me, looking back, now she isn't here, that he was planning to do something to her…".

4.3.34. AF 1 explained that she had planned to take a short break away with her partner the weekend before Adult 1's murder and "before we went away, the last time I saw Adult 2 alive, we watched telly together at home and it was all quite normal. He did ask me about mum, but nothing significant."

4.3.35. Friend 1 also recalled "after she moved in with [her new partner] she started to move her stuff out of Adult 2's and was sharing Adult 2's car. Then Adult 2 would come home and unpack it…so after she moved in with [her new partner]. So [her new partner] bought a car so she could get to work…I saw him out when we were walking the dogs that weekend. AF 1 was away so I asked how he was getting on and he told me that he had accepted her decision and he needed to look forward. We talked about a lad's trip that was coming up and he said he was looking forward to it and I thought he'd finally come to terms with her leaving." Friend 2 says "there was just no clue he was going to do what he did." In the few weeks before the deaths, Friend 2 had seen Adult 2 going to the [local pub], and a couple of weeks before he had paid him some money for a [men only holiday]. However, Friend 1 added that the "first time he saw her new car was the day he killed her…"

4.3.36. AM 1 says that he became aware of the couple's separation the week before the deaths, when "Adult 2 came to see me and told me they had spilt up. She had moved out and was coming back to the house each day to pick things up… he took that particularly hard…[her new partner] was actually a friend of his…Adult 2 was upset about the breakup and still loved her. He told me that he loved her to bits and there were tears in his eyes…he did come to see me the Thursday before it happened, looking back I think he wanted to talk to me, but we never got around to it, but he did say he could understand how it was for me living on my own".

4.3.37. Friend 4 said Adult 2 also confided in him about the couple's separation a couple of weeks before the deaths: "we had gone out for a few beers…he told me he needed to speak to me and said he thought she had someone else, as in another man. I asked him if he had sought help, but he said it had gone past that. He said he knew who [the other man] was and had felt side-lined [by his football friends]." Friend 4 could not recall any discussion with Adult 2 that suggested any violence or abuse between the couple or any financial difficulties: "Adult 2 never talked [to me] about being in debt, he always had loads of money, more than me and I thought he was just tight…". Friend 4 saw Adult 2 twice in the week preceding the deaths, when they went cycling together, and said that everything seemed fine "so what happened was a complete shock…". Friends 1 and 2 disputed that he had been sidelined and said they had "told him we were there for them both, they were both our friends and we viewed them like our son and daughter. He chose not to join us when we went out as a group, perhaps because he was embarrassed or to keep the peace…but he had other friends, was going out with them and was making plans. Like he was looking forward…".

4.3.38. On the morning of the deaths, Friend 2 says he saw Adult 2, who said he had an interview that day for a new role within the firm. Friend 2 believes that the role had been earmarked for Adult 2 and says that Adult 2 didn't appear anxious, "he seemed completely normal and calm, like he was accepting of things". AF 1 and Friend 1 believe that Adult 1 would not have expected Adult 2 to be in the family home as Adult 1 was not aware of Adult 2's interview.

4.3.39. AF 1 says that on the day of the deaths, she returned home from work and noted there was a car outside she did not recognise and the curtains were closed. "I opened the door and saw my mum's keys and sunglasses on the side and thought "mum's here" so called out. There was no answer and when I went into the hallway and saw all the blood, and her clothes covered in it in the hallway, well, I knew then he'd done something…the house was so quiet…I went into the lounge because I saw his feet first, and that's when I saw them, what he'd done…He'd put them in a makeshift bed and I knew straight away they were both dead, and he'd done it so they looked like they were sleeping…I ran to fetch Friend 1 and Friend 2…I can never forgive him for what he did to my mum because of what he wrote in the note – that made me angry, it still does."

5. The Facts by Agency

5.1. Summary of Information in HM Coroner's File

5.1.1. In a planning meeting, the Police representative was clear that the Police were officers of HM Coroner, and they needed the consent of HM Coroner to share detailed information.

5.1.2. In this meeting, the Police representative also confirmed that, according to the Senior Investigating and Family Liaison Officers, the Police investigation had not established indicators of jealous, coercive or controlling behaviour in the couple's relationship, and there was no indication that Adult 2 planned to kill

Adult 1 or end his life. This finding was not supported by the Domestic Homicide Review, which established that the investigation *had* identified a pattern of coercive and controlling behaviour perpetrated by Adult 2 towards Adult 1 throughout the relationship and which escalated in weeks preceding the murder.

5.1.3. In the inaugural Panel meeting, it was agreed that HM Coroner would be asked if the Overview Report Author could access their file, and this was subsequently agreed to ensure all relevant information was shared with the Panel as part of this review. What follows is a summary of information that is not reflected elsewhere in this report:

- . Adult 1 met AF 1's biological father when she was 17/18, and shortly afterward became pregnant with AF 1,this relationship broke down after Adult 1 became pregnant. After the birth of AF 1, Sister 1 said that Adult 1 tried to ensure that AF 1 had contact with her biological father, but by this time he met a new partner so asked Adult 1 to cease her visits with AF 1.

- Adult 2 had suffered with asthma but had not required medical support with this for a number of years. His postmortem tests showed no evidence of him being under the influence of alcohol, prescribed or unprescribed medication prior to his death.

- Adult 2 had one antecedent record for a public order offence of some age (pre the scoping period) for which he received a "bind over" disposal.

- A financial records check showed that, between them, the couple had debts totaling £193,510, which included the re-mortgage against the family home.

- Neither Adult 2 nor Adult 1 had any offences recorded against them.

- Adult 1 began to keep a record of her injuries on her mobile phone. Although the age of some of the mobile handsets did not record the date and time, a very old handset held a photo of an injury to her arm that appeared to be in a cast or splint. Another older handset held photos taken by Adult 1 of her injuries, which include various facial injuries including a bruised eye, a bloodshot eyeball and bruising and swelling to a cheek. A later handset also held photographs that Adult 1 had taken of her injuries that included bruising, cuts, grazes and swelling on various body parts, including her arms and legs.

- On a more recent handset, Adult 1 had made a recording of arguments between herself and Adult 2. These are dated within late 2017, but exact dates could not be retrieved by the Police. In these recordings Adult 2 can be heard threatening Adult 1. Examples include him saying "be aware that if you bang that fucking door I'll bang the door into your head", and "behave like that again and I could have fucking punched you, seriously you were lucky you got away with a fucking bruise to your arm". In another part of this recording Adult 1 says, "what are you going to do, hit me again?" Adult 2's response was "feel like it, yeah", after which he proceeds to accuse Adult 1 of flirting with another man, and he makes threats to harm this person. In another, Adult 1 accuses

Adult 2 of sexually and physically assaulting her. There is no record of Adult 2 denying these allegations.

- Adult 1's new partner gave the Police a statement which outlined how they met some years ago, became friends over time, with a closer relationship developing recently. He said the relationship became intimate in January 2018, but that they had been seeing each other to talk previously. On these occasions Adult 1 confided in him about the frequent physical abuse she was experiencing, perpetrated by Adult 2, and showed him the photographs she had taken. He said that Adult 1 told him her relationship with Adult 2 had completely broken down and they were separating. Adult 1's new partner recalled only one incident in 2017 where Adult 2 was physically aggressive toward Adult 1, when they travelled abroad to watch an away football match, and this resulted in the male members of their group pulling Adult 2 away from Adult 1. He also said that, at the end of March 2018, Adult 1 telephoned him in distress because Adult 2 had been chasing her round the family home trying to attack her, so he immediately attended the family home to help her escape. The couple then stayed in a hotel before Adult 1 moved into his home. During the following two weeks, Adult 1 would return to the family home to collect various belongings or to pick up the car she shared at the time with Adult 2. Her new partner then bought her a car of her own so that she did not have to depend on Adult 2 allowing Adult 1 to use his car.

- In her statement to the Police, AF 1 described the abuse her mother experienced (perpetrated by Adult 2) as worsening after the couple married 6 years before they died. She recalled that verbal abuse was a daily occurrence, and this would become physical every few months. AF 1 also said that, in relation to the incident which occurred when the couple returned from their honeymoon, that is described by Friends 1 and 2 above, she recalled hearing photographs being smashed and then screaming. She came out of her room to see Adult 2 strangling her mother, who was trying to phone the Police. She saw Adult 2 take the phone away from Adult 1 and would not let it go, at which point AF 1 asked Friend 1 to try and calm her parents down.

  AF 1 also told the Police that, prior to Adult 1 leaving the family home, Adult 2 became suspicious that she may be seeing someone else and followed Adult 1. He saw Adult 1 getting out of an unfamiliar car. This confirmed his suspicions and Adult 2 confronted Adult 1 the following day. Prior to the confrontation, Adult 2 had shut the kitchen door, so the camera could not capture his actions, and AF 1 shared her belief that Adult 2 planned to hurt Adult 1.

  AF 1 also told the Police that, after Adult 1 had moved out, there was an occasion when she returned to the family home to collect some belongings or use their car. Adult 2 offered to move into the spare bedroom to allow Adult 1 to move back into the family home. Adult 1 refused and told Adult 2 that she did not want to. AF 1 described the atmosphere in the house as being tense and awkward because Adult 2 kept asking her questions about Adult 1.

  AF 1 also stated that Adult 2 was facing redundancy at work, and he became agitated because he was losing his job and his wife. He also began to worry

that Adult 1 would replace him on a planned holiday, and he had been ringing Adult 1 persistently about this.

- In her statement to the Police, Friend 1 said that in the past Adult 1 would confide in her about the abuse she was living with but stopped discussing it with her more freely after Friend 1 suggested that Friend 2 could speak to Adult 2, and Adult 1 declined because she was worried "Friend 2 would give him a hiding". After their marriage, Friend 1 also recalled that Adult 2 became more possessive about his belongings and began to view Adult 1 in the same way. Friend 1 also recalled that, about two years before the deaths, Adult 1 had the perception that the couple were no longer in a relationship although they continued to live under the same roof for the sake of AF 1. Friend 1 was concerned that Adult 2 did not share this view because they still socialised and did things together.

  Friend 1 also said in her statement to the Police that Adult 1 formally left the family home two weeks before the deaths, and Friend 1 spoke to Adult 2 because she was concerned about his well-being, but also because Adult 1 had told her, in the past, Adult 2 had told her he would kill her if she left him. In this conversation, Friend 1 recalled Adult 2 said that Adult 1 "will never leave me" and he did not want her to leave because "I will never get her back". Friend 1 described how Adult 2 presented as being lonely after Adult 1 left the family home, and how she tried to persuade him to move forward with his life.

- Telephone data obtained during the murder investigation included text messages from a number of mobile phones. From this a data timeline can be built:

  - 29.03.2018: Adult 1 informs her new partner by text that she intends to tell Adult 2 about the relationship.

  - 30.03.2018: Adult 1 confirms to her new partner that she has told Adult 2 about her relationship, but not who her new partner is, and that Adult 2 does not want her to leave the house. She sends similar texts to three of her friends, including Friends 1 & 3.

  - 17.04.2018: Adult 2 messages Adult 1 and states he misses her and is finding things hard, that he is struggling to cope with their breakup and his redundancy. He indicates his acceptance that Adult 1 is going to move out of their home.[7]

  - 17.04.2018 – 29.04.2018: Adult 2 increased attempts to contact Adult 1. She did not respond to these. Adult 2 sent his final text to her on the

[7] This was discussed by the Overview Report Author with the Officer in the Case (OIC). The OIC advised that, in the text message exchange on 17.04.2018, Adult 1 told Adult 2 to leave her alone and that she was not going to respond to any further messages or answer his calls. Also, in this period, there were a high number of texts and missed calls from Adult 2 to Adult 1, which peaked at 25 in one hour in the evening two days before the incident.

evening of 29.04.2018 in which he asks how he is supposed to live without her.

- 30.04.2019: Adult 1 exchanged some messages with her new partner during this afternoon. Her new partner sent his final message to her at 16:10 and it is believed that Adult 1 was significantly harmed by Adult 2 around this time. AF 1 also rang Adult 2 numerous times and text Adult 2 just after 18:00 and he did not respond (AF 1 told the Police this was not usual), and it is believed that both were deceased by this time.

- In a statement to the Police, made by a representative of Adult 2's employer, it was confirmed that Adult 2 was advised he was "at risk" of redundancy, and then he attended a formal consultation meeting prior to the murder of Adult 1. During this meeting, his employer explained the criteria that would influence their decisions on who would be made redundant and the timescales. No concerns were recorded, and Adult 2 then attended an interview on the morning of the deaths. Adult 2 was described as performing well in the interview, as being relaxed and talkative, outlining his skills and desire for promotion. The interviewer assumed that Adult 2 was remaining on site to work, as he attended the interview wearing his uniform. The statement also outlined that the "at risk of redundancy policy for this firm enables employees to remain at home and only attend work if they are called to attend because there is work available for them". The statement outlines that other colleagues saw Adult 2 prior to his interview, but not after and it would appear he left the site shortly after his interview, which is confirmed by a CCTV sighting. None of the employees had any concerns about Adult 2's presentation or behaviour on that morning. A colleague who worked in close proximity to Adult 2 also provided a statement to the Police, saying that he was a quiet man who would make polite conversation but never discussed his life outside of work or the redundancy.

- Forensic evidence indicated that a violent altercation began in the kitchen and Adult 1 was at least unconscious when she was dragged into the hallway where Adult 2 removed her clothing, with the exception of her underclothing. There was evidence that he tried to take her body upstairs but then placed her body in the living room. Adult 2 then went upstairs, removed bedding from the master bedroom and made a makeshift bed in the living room, in which he placed Adult 1. He then removed his own clothing, with the exception of his underwear[8], inflicted wounds on himself before lying down beside her. There was no evidence of pre- or post-mortem sexual assault or activity.

- There was a note which was left with the bodies. The investigation concluded this had been authored by Adult 2. It was addressed to AF 1. It says:

  "I am so sorry it has come to this. It's too much to handle, too much pain. I love my wife, your mum, too much to ever let go. One day I hope you can forgive. We are now together forever, and finally ended up at home,

[8] It was subsequently confirmed with AF 1 that Adult 1 and Adult 2 would sleep in their underwear.

husband and wife. If you do get married in the future, take your marriage vows seriously. You now have to move forward and make the most of your life. Make the most of it and look after those in it. Mum and me will always love you. You know how much we love you. We will be looking over you forever, our special daughter. Our love always and forever. Adult 2 and Mum xxx"

5.2. GP Surgery 1

5.2.1. The Individual Management Review (IMR) report provided by this agency noted that all staff within the practice, both clinical and ancillary, are given a mandatory suite of eLearning training which includes the safeguarding of children and adults. All staff are trained to recognise different types and potential indicators of abuse or neglect, including potential indicators of domestic violence or abuse and coercive or controlling behaviour. All staff are aware of and have access to the CCG's Safeguarding Children and Adult Policy and Protocols. The Senior Partner and Safeguarding Lead are the nominated points of contact for all safeguarding concerns within the practice, including domestic violence and abuse.

5.2.2. GP Surgery 1 records indicate that they had provided General Practitioner services and care to Adult 1 since 1995. Adult 1 attended 28 appointments with practice staff, of which 13 were GP appointments, during the period of the review for routine consultations. Adult 1's only recorded familial relationship is with AF 1. From a review of the records, the IMR author noted no interactions or indicators that would have indicated a potential safeguarding or domestic abuse concern with regard to Adult 1 or AF 1.

5.3. Leicestershire Police

5.3.1. The IMR report provided by this agency recorded that the first contact with Adult 1 and Adult 2 occurred in 2002. The details are that, at 2:15am on Sunday 25th August 2002, Adult 1 contacted Leicestershire Police regarding a domestic incident with Adult 2 and requested police attendance. Officers attended and spoke with the couple. The Officers established that a heated verbal argument had taken place between the couple, but it is unclear to the IMR author, having reviewed the available documentation, what this argument was about. As no offences had been committed, a Domestic Incident Non-Crime report was completed. The incident was subsequently reviewed by a Domestic Violence Officer who deemed that no further action was required.

5.3.2. No further incidents are recorded until 2017. In the Spring of 2017, Adult 1 made a 999 call to Leicestershire Police and stated that Adult 2 had returned home drunk and was threatening to hit her. It was noted by the IMR author that, during this call, Adult 1 was upset and crying. She also disclosed that Adult 2 had previously assaulted her, and she was frightened although he was currently sitting down, looking at her and shaking his head. On attendance at the couple's home address, the Officers attending this incident spoke initially to Adult 1, who was apologetic for having called the Police. They then spoke with Adult 1 and Adult 2 separately.

5.3.3. The Police report that Adult 1 informed the Officers that:

- She had been married to Adult 2 for 23 years
- The couple had one daughter (AF 1) who had grown up and moved away
- Adult 2 worked hard at his job during the week but at weekends he would go out to local pubs and get drunk. When he returned home, he would be aggressive towards her and threaten to hit her, resulting in her being afraid of him and his ability to carry out his threats.

5.3.4. Adult 1 also disclosed that he had previously assaulted her, but she had not reported this to the Police. She stated that she now accepted that the marriage was over and would seek further advice from her place of work (she was a legal secretary at a local firm of solicitors) to instigate divorce proceedings.

5.3.5. A Domestic Abuse, Stalking and Harassment and "Honour" Based Violence risk assessment (DASH) was completed with Adult 1. During this assessment, Adult 1 disclosed that she suffered consistent abuse at the weekends following Adult 2's heavy drinking; she was frightened he may carry out his threats at some point; and he had assaulted her on one previous occasion, but this had happened a number of years ago. Due to the low number of positive answers Adult 1 gave (2 out of 27 questions), the risk was graded as 'standard'.

5.3.6. The attending Officers noted they felt that Adult 1 was possibly at risk of some kind of harm; the level of harm was not quantified but was not sufficient to have changed the level of risk on the DASH risk assessment and an Adult Safeguarding Referral was created. This was cancelled during the review of the incident by a Supervisory Officer the following day because Adult 1 did not fit the definition of a vulnerable adult as detailed below:

'A person is vulnerable if, as a result of their situation or circumstances, they are unable to take care of or protect themselves or others from harm or exploitation'.

5.3.7. The IMR author explained that the attending Officers wore body worn cameras, but the footage no longer exists. There was also no record of Adult 2's version of events on this occasion.

5.3.8. The second time the Police attended the couple's home was in relation to the fatal incident, following which a murder investigation began. This established that no other persons were involved, and a detailed file was submitted to HM Coroner. The investigation uncovered a history of previous domestic abuse perpetrated by Adult 2 and included undated photographs of injuries (bruising, scratches and a broken arm) that Adult 1 had sustained which were recovered from her mobile phone, as well as audio recordings of arguments taking place where Adult 2 was making threats to assault Adult 1. Some of these photographs dated back to 2013. The audio recordings display Adult 2's aggressive behaviour towards Adult 1 and he also made admissions of previous assaults against her. An audio recording of the domestic incident detailed in 2017 was also recovered which supports Adult 1's account of the events. However, Adult 1 did not disclose the existence of this recording to the

attending Officers. The investigation also revealed that family and friends were aware or suspected that Adult 2 was physically abusive toward Adult 1 and that in 2018 she had started a new relationship.

6. Analysis against the Terms of Reference

The terms of reference, as agreed by the Panel, were analysed in light of the information gathered as part of this review.

6.1. To review if practitioners involved with the family were knowledgeable about potential indicators of domestic violence and/or abuse, including coercive control, and aware of how to act on concerns/indicators about domestic violence and/or abuse to ensure early intervention and support

6.1.1. Due to the minimal agency involvement with the family, with one exception which is explored in further detail below, there was minimal opportunity for professionals to identify potential indicators of domestic abuse. It was also apparent, from discussions with Adult 1's friends and family, that Adult 1 would be unlikely to engage with or access support from professionals.

6.2. To determine if appropriate consideration to accessibility to support was given by agencies involved with the family when making decisions in terms of the level and support provided to members of the family, including the family's capacity to understand those decisions and how they could respond to those decisions

6.2.1. Due to the minimal agency involvement with the family, there was minimal opportunity for professionals to signpost or refer any member of the family to support.

6.2.2. When the Police attended a domestic abuse incident at the couple's home in 2017, the Panel accepted the Safeguarding Adult Referral being cancelled was appropriate, as the referral had been made in error. It was evident to the Panel that Adult 1 did not cross the threshold for being considered as a vulnerable adult. The Panel were unable to establish if the responding Officers gave any consideration to the impact of the pattern of abuse Adult 1 disclosed to them. The Panel noted that that this incident occurred prior to the delivery of DA Matters[9] training to Leicestershire Police and determined that it was likely

[9] http://www.safelives.org.uk/training/police/about Domestic Abuse Matters is a training programme delivered to Police Officers and focuses on the issue of domestic abuse and coercive controlling behaviour and is structured with a view to implementing long-term attitudinal and behavioural change in police forces.

https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/2014/04/improving-the-police-response-to-domestic-abuse.pdf This report called for a review of Police training in relation to domestic abuse and the DA Matters programme was developed in response to this learning.

In HMIC's update report, https://www.justiceinspectorates.gov.uk/hmicfrs/publications/the-police-response-to-domestic-abuse-an-update-report/, it was noted that where Police forces had committed fully to the DA Matters program, significant improvements were noted in Police responses to domestic

the officers did not recognise the importance of determining if the patterns of the abuse Adult 1 was experiencing had impacted on her capacity to make decisions[10].

6.2.3. The Panel were satisfied that, in line with policy and procedures that existed at the time, cancelling the Safeguarding Adult Referral was an appropriate action. However, it noted that the definition of vulnerable adult which applied at the time does not fit with the 2014 Care Act definition of a vulnerable adult, but the Panel were reassured that the Police have adopted use of the definition used by the College of Policing. It was acknowledged that this was to support frontline officers and practitioners to use their professional judgement rather than undertaking a high level of analysis which the Care Act definition could require. This enables the analysis to be undertaken by the Adult Referral Team who have been trained to undertake the required level of analysis. The Panel make no recommendation in relation to this finding.

6.3. To establish if there were any opportunities for professionals to "routinely enquire" if domestic abuse, including coercive control, was being experienced by the victim that were missed, and if those enquiries would have recognised the victim's need for appropriate support, in line with national best practice

6.3.1. The IMR author for GP Surgery 1 noted that, during the scoping period, Adult 1 attended for routine medicines reviews, including for contraception. It was recognised by the IMR author that this presented an opportunity to routinely enquire about Adult 1's intimate relationships, which would have been an opportunity for GP Surgery 1 to capture Adult 1's partner's details so they could be added to her medical record, where appropriate. In addition, the IMR author noted that such an approach, had it been utilised, had the potential for Adult 1 to disclose instances of abuse. The IMR concludes that such discussions with Adult 1 were not recorded, and the Panel agreed with the IMR author's conclusion that the lack of recording of these discussions indicated they may not have happened. The Panel also supported the recommendation made by the IMR author to ensure such discussions were recorded in future. The Panel also received reassurance that this was communicated to Practice staff expediently. Being aware that this learning has been identified in other Domestic Homicide Reviews in the Leicestershire area, and that addressing this is ongoing activity that is reported to the LLR DVSA Operational Group, the Panel make no recommendation in relation to this finding.

6.4. To explore if there was appropriate information sharing between agencies in relation to any family members, including if any agency or professionals consider any concerns they may have raised were not taken seriously or

abuse incidents https://www.justiceinspectorates.gov.uk/hmicfrs/publications/the-police-response-to-domestic-abuse-an-update-report/.

[10] https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf

acted upon by others and how information sharing can be improved to safeguard families impacted by domestic abuse

6.4.1. Due to the very limited involvement of agencies in this case, the Panel could not find any evidence to suggest that information sharing between agencies was not taken seriously or required improvement. This was a perception that AF 1 also shared with the Panel, who noted that Adult 1 was "a very private person and would not have told anyone professional what was going on…even when I was little she would do everything she could to make sure I did not hear or see anything untoward going on between her and Adult 2." It follows that agencies did not have any opportunity to identify or share concerns about Adult 1 or her family.

6.5. To establish how professionals carried out assessments, including whether:

i. assessments and management plans in relation to any family member took account of any relevant history

6.5.1. There was one prior report of a Non-Crime Domestic Incident recorded in 2002 and, whilst this added context to the history of the dynamic within the relationship, it is noted that this incident was out of the scope of the review. It was also noted that, in 2002, risk assessment with victims of domestic abuse would have been undertaken with the SPECCS+ tool, which has been superseded by the DASH risk identification checklist.

6.5.2. A DASH Risk Assessment was undertaken with Adult 1 by Leicestershire Police in 2017, by the Officers who responded to her 999 call for assistance. Once the Officers identified her as the primary victim in order, they then asked the 27 risk identification questions in line with the practice guidance.[11] In line with the guidance, the completing officer recorded the 'yes' or 'no' responses given by Adult 1 to each question and provided additional text to add context to the 'yes' answers where appropriate. Adult 1 gave two positive responses to the DASH questions. The completing Officer also added their own professional judgement regarding the identified risk, which was recorded as 'Standard' risk, defined within the DASH guidance as 'current evidence does not indicate likelihood of causing serious harm'[12].

6.5.3. The Panel noted that, beyond the responses given to the Officers by Adult 1, there was information recorded in the initial 999 call given by Adult 1. This information indicated additional risk indicators disclosed by her, and that could have potentially affected the risk score of this initial assessment:

- Impending separation

[11] DASH Practice Guidance (ACPO 2009)

[12] DASH Practice Guidance ACPO 2009) – risk thresholds are defined in line with Offender Assessment System (OASys) definitions developed by the Prison and Probation Services of what constitutes standard, medium, high risk.

- Use of alcohol/drugs
- Frequency of abuse
- Escalation.

6.5.4. The Panel agreed that the application of professional judgement could have been informed by the information shared by Adult 1 during her 999 call. This included that Adult 2 was present when Adult 1 was making this call and was "shaking his head", and the Panel agreed this *may* have been an indication that Adult 2 was coercively controlling Adult 1 during her conversation with the Police, but the impact of this gesture on Adult 1 was not scoped out to definitively establish this hypothesis.

6.5.5. While this might appear that the attending Officers did not recognise the risks correctly, the Panel noted that Officers, in line with the DASH guidance, must record the answers given to them when they ask the questions, even if this appears to be at variance with information recorded elsewhere, and *then* record their professional judgment, which enables them to include other sources of readily available information, *before* assigning the risk threshold.

6.5.6. There was discussion as to what the most appropriate risk threshold would have been, which identified that the outcome of a DASH assessment using the DASH tool can be impacted by many variants, including a tendency for professionals to use the DASH tool as a checklist without applying professional judgement. The Panel agreed that, even if Adult 1 had been identified as a victim of coercive control, the risk threshold in this case, in line with the existing domestic abuse protocols at this point in time, would have been medium at most, and so specialist domestic input from a Domestic Violence Officer would not have been allocated to Adult 1. In this context, the Panel agreed that the assigned risk level was appropriate, and that, even if a medium risk level was assigned, Adult 1 did not fulfill the criteria for a vulnerable adult referral. It was also recognised by the Panel that, nationally, understanding and consistency around application of the DASH process varies between forces. Such issues were highlighted by HMIC in their national report 'Everybody's Business'.[13] Following a recent review led by the College of Policing, which included the opinions of leading academics and subject matter experts, the DASH risk tool is under review with a new risk model currently on trial in five police force areas[14]. As such, the Panel do not make a recommendation in relation to these findings.

ii. The history of domestic abuse was fully considered alongside evidence led approach set out in the Criminal Justice Act 2003 to support gathering evidence of coercive and controlling behaviour (contrary to S76 of the Serious Crime Act 2015)

[13] Everyone's Business (HMIC 2014).

[14] Piloting a new approach to domestic abuse frontline risk assessment (College of Policing 2018).

6.5.7. Friend 1 described how Adult 1 would often attempt to diffuse Adult 2's behaviour and only phone the Police when "her strategies to manage Adult 2's behaviour did not work effectively for her, saying…when Adult 1 phoned the Police she was terrified of Adult 2 and what he was threatening to do to her…but things would have calmed down by the time they arrived and then she wouldn't talk to them". The Panel noted that Adult 1 phoned the Police twice (in 2017), prior to her murder and Friend 1 confirmed that, after this event, Adult 1 would often tell Adult 2 that she would phone the Police if he did not calm down.

6.5.8. In the absence of evidence to the contrary, the Panel hypothesised that Adult 1's threatening to phone the Police was a safety strategy deployed to manage her safety when Adult 2's behaviour caused her to fear for her safety. Adult 1 did not disclose to the Officers attending the second incident reported to them the recording she made of the previous incident that occurred in 2017 and which the Police attended. Friend 1 also stated that Adult 1 "after she phoned the Police and they came out, she would tell him [Adult 2] she was going to phone them to calm him down if he started to scare her. And then she said he would stop scaring her." The Panel agreed this may explain why Adult 1 did not report further incidents to the Police.

6.5.9. Already discussed elsewhere in this report is the missed opportunity to arrest Adult 2 for the assault on this occasion and the previous assault that Adult 1 disclosed to the Officers. When the Panel were discussing the Police response to this incident, it was noted that Adult 1 was describing to the Police a *pattern of repeated and continuous behaviour that made her frightened* – namely Adult 2 drinking at the weekend and returning home under the influence of alcohol, when he would threaten to harm her. In this case, the Panel agreed this behaviour crossed the threshold as prescribed in the statutory guidance for the offence of coercive controlling behaviour[15]. The Panel agreed that, when incidents are viewed as singular incidents in isolation of each other, rather than interlinked parts of a much bigger pattern of behaviour which have an adverse effect upon the victim, then the opportunity to address that behaviour using appropriate legislation can be missed. It can be argued that this approach was a missed opportunity to consider an evidence led investigation that may have resulted in further Police action in relation to the offence of coercive and controlling behaviour.

6.5.10. When the Officers left the couple's home in 2017, they were concerned for Adult 1's safety, though could not articulate why. The statutory guidance in relation to the offence of coercively controlling behaviour specifically states that 'the Police should also be aware that in cases of domestic violence and abuse where there is not enough evidence to charge for a physical injury,

15 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf "Coercive behaviour is: a continuing act or a **pattern of acts of assault, threats**, humiliation and intimidation or other abuse that is used to harm, punish, or **frighten** their victim."

there may be enough evidence to charge for the new offence of controlling or coercive behaviour[16].'

6.5.11. However, it is also noted that this incident was responded to *before* Leicestershire Police Officers received the DA Matters training and this is addressed in 6.2 above. It is understood that Leicestershire piloted this training being received by frontline responders. During the course of the review, in addition to Panel discussions, other discussions took place with Police Officers. These discussions identified that awareness of coercive control as a pattern of behaviour may not be fully understood or not fully recognised, and there was a tendency to seek out individual indicators of coercively controlling behaviour. Whilst the discussions were outside of the scope of the review, it is learning relevant to this review. It is also understood that there is the intention for other Leicestershire Police Officers to receive the DA Matters training in the future. The Panel recommend that this training should be received by officers who review the responses to incidents attended by frontline responders.

iii. Were the principles of positive action applied and/or the statutory guidance for the offence of coercive control considered in responses?

6.5.12. Police Officers have a positive obligation to take reasonable action within their lawful powers to safeguard the rights of victims and children, including the duty to make an arrest where it is necessary and proportionate to do so, to protect victims and others from harm. If Adult 2 had been arrested following the 2017 incident, this would have allowed Officers to obtain evidence by questioning him. Although the IMR solely referred to the historic offence of assault, it did state that the arrest of Adult 2 in 2017 would have offered the potential of a much broader range of investigative opportunities. The Panel agreed with this finding.

6.5.13. Other available evidence included officer body worn video, the 999 call and Officer statements regarding Adult 1's demeanor and any account from Adult 2 during interview. The provisions of the 2003 Criminal Justice Act allow for evidence led prosecution to be considered where the victim is unable to support a prosecution through fear to reduce reliance on the victim as the sole source of evidence. Whilst the Panel noted that the Officer body worn video was potentially a rich source of evidence available, at the time, because the incident was not recorded as a crime, and was logged as a "Domestic Incident – Non-Crime", the body worn footage would not have been considered as evidence.

6.5.14. The 2014 Body Worn Video (BWV) guidance states 'the decision to retain footage will be a matter of judgement in every case as some material may be relevant to the ongoing monitoring of a situation, but other material may need to be deleted immediately. For example, BWV recorded in private dwellings is always likely to be sensitive and intrusive, and footage that is not relevant to

16 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

any criminal investigation or prosecution should normally be deleted in line with local force information management policies. However, in circumstances where there is ongoing concern for victims and their children, it may be appropriate to retain material for longer periods as doing so may help protect them, or, at a future time, provide evidence for courts to consider in proceedings such as applications for non-molestation orders'.

6.5.15. In line with the Police's retention policy, the footage was deleted once the requisite period of time lapsed. The Panel were reassured that this approach is in line with current Policing standards, and so make no recommendation in relation to this.

6.5.16. The Panel noted that the responding officers did not speak to neighbours or friends/family. It was not clear to the Panel, had friends and family been contacted by the Police in 2017, if they would have been able to assist the Police or not. The Panel did note that some of the couple's friends were, by this time, beginning to suspect all was not well in the couple's relationship. However, the Panel also noted that the DA Matters training had not been received by Leicestershire Police at this point in time, and so the responding Officers would have been unlikely to have recognised the value of undertaking an evidence led approach to coercive control which would have included speaking to neighbours or friends/family. The 2017 Peel report for Leicestershire Police stated that "victims of domestic abuse now receive a better service from the force"[17]. As such, the Panel do not make a recommendation in relation to this finding.

6.6. If any contacts with any family could have afforded opportunities to assess risk and/or identify any warning signs of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals, including the use of markers/warnings indicators within agency systems

6.6.1. The Panel found that professionals were not aware of the abuse that Adult 1 was experiencing and so there presented no opportunities to identify or assess the risk posed to her by Adult 2 in the months, weeks and days preceding her death.

6.7. To identify whether the Leicestershire and Rutland Safeguarding Board/Community Safety Partnership needs to consider any learning that would require further strategic review and/or analysis to inform tactical and operational responses when supporting victims or identifying/appropriately challenging perpetrators of domestic abuse within the local community.

6.7.1. In 2017, Adult 1 requested Police assistance and disclosed three offences to the Police. Adult 1 had told Officers she was scared and disclosed recent and historical assaults as well as coercive and controlling behaviour, and the Panel agreed that she was living with 'violence or threat of violence' that she needed

[17] https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-police-effectiveness-2017-leicestershire.pdf

to be protected from. The arrest of Adult 2 would have provided Officers an opportunity to investigate these and enable consideration of an evidence led prosecution.

6.7.2. In a 2017 National HMICFRS report, concerns were recorded that Officers appear to have a working knowledge of what is needed to prosecute without a victim's support, but there is little evidence to demonstrate that evidence led prosecutions are routinely considered[18]. The Panel agreed that, if after careful consideration, the available evidence following investigation did not result in a charge or bail conditions the Investigating Officer could have considered the application process for a Domestic Violence Protection Notice (DVPN).[19] This would have required Adult 2 to leave the property for 48 hours and could have been followed by an application to the magistrates court for a Domestic Violence Protection Order (DVPO) which can result in removal from the premises for a further 28 days.

6.7.3. The rationale is to give the a 'victim' of domestic violence immediate support and 'breathing space' in which to seek help & assistance. The process can be pursued without the victim's active support, or even against their wishes if this is considered necessary to protect them from violence or threat of violence. A suspect can make representations on the imposition of the DVPN or DVPO, but their consent is not required for them to be imposed. The victim also does not have to attend court. This can increase victim confidence as this approach removes responsibility from the victim for taking action against their abuser[20].

6.7.4. College of Policing guidance also highlights that use of this process "allows a wide interpretation to include any behaviour by the perpetrator which instils a fear of violence in the victim…there are Human Rights implications to making a person temporarily homeless by issuing a DVPN and it is good practice to provide the suspect with details of emergency accommodation when serving the notice…The suspect should be referred to a voluntary perpetrator scheme if available in the force area." The Panel heard the application process in Leicestershire requires sign off by a Senior Police Officer. It did note that the DVPN/PO process could be used as a tool for early intervention, or in cases of domestic abuse that feature economic abuse, as they provide opportunity to engage with services to deal with the economic insecurity, and safely manage any separation through a risk management plan. The Panel agreed that, although this process could have been offered to Adult 1, and as a victim of domestic abuse she may have benefited from breathing space to assess her options for support, not offering this Order to Adult 1 was proportionate to the risk posed to her at that moment in time.

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[18] A progress report on the police response to domestic abuse (HMICFRS 2017) https://www.justiceinspectorates.gov.uk/hmicfrs/publications/peel-police-efficiency-2017/

[19] Crime and Security Act 2010 Crime and Security Act 2010 (legislation.gov.uk)

[20] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/arrest-and-other-positive-approaches/domestic-violence-protection-notices-and-domestic-violence-protection-orders/

6.8. To identify learning in relation to community awareness, including how community and/or faith groups and other potential access points are supported to identify Safeguarding issues and/or victims of domestic abuse and share concerns with professionals, including if pathways for community and/or faith groups require development

6.8.1. From the conversations with friends and family, the Panel noted the following themes:

- There was awareness in the couple's social and familial circles that escalating domestic abuse, including economic control, were features of Adult 1's lived experience in her relationship with Adult 2
- The collective perception that Adult 1 needed to be the one to speak to the Police in order to access support
- The belief of friends and family that Adult 1 needed to separate from Adult 2
- A vague recognition of support available to Adult 1 but a lack of awareness on how to obtain more information on this support, or what this support would entail.

6.8.2. Sister 1 also informed the Panel that Adult 1 was constantly taking paracetamol, although her reasons for self-prescribing and self-administering this analgesic is unknown.

6.8.3. The Panel established that, in 2017, a booklet for friends and families who are concerned about a victim of abuse was released. Despite this, the emerging themes highlighted that awareness of pathways to support for victims of domestic abuse are not well known to the public. Confidential third-party reporting, how separation can increase risk where domestic abuse is a feature and support available to victims of domestic abuse are not well known within the community in which Adult 1 lived.

6.8.4. Domestic and Sexual Support Services in Leicestershire are delivered by UAVA. Living Without Abuse (formally Loughborough Women's Aid) is a member of the UAVA consortium and have been managed by UAVA since 2015. The Panel heard that Living Without Abuse had been working in partnership with the CSP to ensure the circulation of leaflets and posters in the area across community venues in the first 2 years of the scoping period. Access to some of the materials from Living Without Abuse that were in circulation was enabled, and, whilst these did reference coercive control and economic abuse, there was no detailed information on how these can impact on victims of domestic abuse or information on how friends and family can support victims or share concerns. As such, it is understandable that those supporting Adult 1, based on this literature, would have formed the view that victims of abuse were the ones who needed to access support. There was also no evidence that community ambassadors, who are equipped to offer safe spaces to access advice and support in local business and community

settings[21] (where Adult 1's friends and family or victims experiencing coercive control and other forms of domestic abuse can talk to someone and get the help they need quickly) had been promoted or developed in this area.

6.8.5. The review also identified that GP Surgery 1 did not display any posters or leaflets in the patient waiting areas which would encourage or reassure potential victims that they are able to disclose safeguarding concerns or experiences of abuse to their GP in confidentiality and safety. The Panel were reassured that this was being addressed within the Practice in a responsive manner and make no further recommendation in relation to this.

6.9. To review the appropriate use of legislation and relevant statutory guidance pertinent to the family's situation

6.9.1. Although the Police IMR author states that Adult 1 disclosed one historic offence of assault, it was evident to the Panel that she disclosed two further separate offences:

- In addition to the historic assault she disclosed to the Officers, she also disclosed a current Section 39 assault by Adult 1 to Police in 2017 as she apprehended the immediate infliction of unlawful force upon her by Adult 2. For a Section 39 offence to be committed, no physical violence needs to follow the threat, just the fear experienced by the victim. Case law has clarified the legislation stating where there is also a battery, the defendant should be charged with 'assault by beating'[22]. Given that Adult 2 was not charged with assault or assault by beating in 2017, it suggests that the two attending Officers may not have appreciated or been aware of this distinction and instead interpreted a common assault as an assault by beating.

- In describing the repeated and continuous pattern of alcohol fuelled threats by Adult 2 towards her, Adult 1 disclosed Controlling and Coercive Behaviour (CCB) contrary to Section 76 of the Serious Crime Act 2015, as the behaviour she described was more than a single incident. The behaviour must have a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victim's day to day activities". Adult 1 told the "Officers that she was frightened that at some point Adult 2 would carry out his threats to assault her".

6.9.2. Professor Evan Stark describes such behaviour as 'the most common context in which [women] are abused…it is also the most dangerous as victims can generalise the fear this behaviour induces in them". The Panel noted that, whilst Adult 1 appeared to recognise the risk posed to her by Adult 2 and took steps to manage her safety, she may have outwardly demonstrated the generalised fear (as described by Professor Stark) in the final weeks of her life. This was evident from the accounts of both AF 1 and Friend 1. Both stated

[21] Change that Lasts: the right to response to domestic abuse https://www.womensaid.org.uk/our-approach-change-that-lasts/askme/

[22] *DPP v Little* (1992) 1 All ER 299 DPP v Little [1992] 95 Crim App R 28 (oxbridgenotes.co.uk)

that Adult 1 disclosed to them that the coercive control Adult 2 exerted continued after her separation from him. This included stalking Adult 1 and her new partner, but there was also evidence that Adult 2 continued to target Adult 1 by stalking her within in the family home. This specifically included Adult 2 hiding in the family home and creeping up on Adult 1 with the intention to scare her when she returned to the family home to collect her belongings. Although this was seen by Adult 1 as odd, Friend 1 said that "Adult 1 said she would go to the house to collect her belongings. She told me the house appeared to be empty when she went in it, but when she bent down to take off her shoes, Adult 2 had crept up on her and would laugh at her jumping out of her skin because she never heard him coming…she told me she felt scared by it but she said she didn't think he wouldn't hurt her". This also suggests that awareness of post separation abuse, including changes in the pattern of coercive control, including indicators that it may be escalating as an abuser has a sense of finality resulting from their perceived loss of control, is not well known within the community where Adult 1 lived, as discussed above.

6.10. To consider how issues of diversity and equality were considered in assessing and providing services to the family's protected characteristics under the Equality Act 2010 – age, disability, race, religion or belief, sex, gender reassignment, pregnancy and maternity, marriage or civil partnerships. This will include consideration of how agency awareness and understanding of relevant cultural, race, religious or nationality issues, and consideration of equality duties, impacted on responses and interventions

6.10.1. The ways Adult 2 used economic and financial resources to control Adult 1 have been recorded earlier in this report – for example, not enabling Adult 1 to have any auditable link to the family home and paying off her credit card debt, which Adult 1 believed was Adult 2's attempt to try and prevent her leaving the relationship. Adult 1 reported to Police and friends that her relationship was over, and that she was seeking a divorce. She was in substantial debt, so this would have limited her options to move on, in this case into the home of her new partner. It also noted accounts from her friends that Adult 1 was not "a person who would have easily accessed support" in relation to her financial situation.

6.10.2. The Panel considered if financial abuse was a feature in the dynamic of Adult 1 and Adult 2's relationship. It noted that the anecdotal examples shared with the Panel gave the clear impression that Adult 2 appeared to control how Adult 1 acquired, used and maintained money and economic resources, such as accommodation, food, clothing, socialisation and transportation. These include, but are not limited to,

- Adult 2 insisting that the couple's financial accounts were separate
- Adult 2's insistence that all loans and credit cards were in Adult 1's name
- Adult 2's expectation that Adult 1 provide food for herself and AF 1

- Adult 2 not allowing either Adult 1 of AF 1 to eat the food he provided for himself
- Adult 2 refusing to provide Adult 1 with financial support for AF 1
- Adult 2 appearing reluctant, when the couple socialised with friends and family, to take his turn to buy drinks which resulted in Adult 1 feeling publicly embarrassed and her giving Adult 2 the money to do this
- Adult 2's insistence that the couple maintain a social lifestyle that was jointly funded although he earned a higher salary than Adult 1
- Adult 2's insistence that the couple could manage with one shared vehicle that he referred to as his, and would stipulate when she could use this vehicle after they separated
- Adult 2's reluctance to contribute any finances toward the couple's wedding and honeymoon.

6.10.3. The Panel considered these examples alongside the definition of economic abuse[23] and noted this clearly is defined, within relationships, as "one-party restricting access to the other party's economic resources and is wider than financial abuse and is designed to limit their freedom…and is experienced within a pattern of coercive control". It concluded that, whilst neither Adult 1 nor Adult 2 may have recognised it, Adult 2 was using economic abuse to level control over Adult 1.

6.10.4. Relevant academic research shows that women living within above average socio-economic groups can be at increased risk of economic abuse as greater financial resources offer greater opportunity for this form of domestic abuse to be hidden. In addition, the threat and fear of poverty acted to trap women in the relationships and the perpetrators exploited this fear.[24] In a study of different forms of economic abuse, it was identified that 89% of women involved in the study reported economic abuse as a part of their domestic abuse and that the economic abuse was known to continue after the relationship had ended[25]. Further research in this subject area shows that "For some of these women, coming forward can be a scandal risk. Many more may not even be aware that they are victims of abuse".[26] Further research into the

[23]Hoge, Gretchen; Stylianou, Amanda; Postmus, Judy; Johnson, Laura, "Domestic Violence/Intimate Partner Violence and Issues of Financial Abuse and Control: What Does Financial Empowerment Look Like?", 2019 https://survivingeconomicabuse.org/economic-abuse/what-is-economic-abuse/

[24] Weitzman, 2005, *Not To People Like Us: Hidden Abuse In Upscale Marriages*, Peresus *Open Ebook - 304 pages - 978-0-7867-2251-8*

[25] Sharp, 2008, "What's yours is mine", Refuge UK www.refuge.org.uk /files What's yours is mine (refuge.org.uk)

[26] Nicola Sharp-Jeffs with Sarah Learmonth, December 2017 P743-SEA-In-Plain-Sight-report_V3.pdf (survivingeconomicabuse.org)

Outlaw, M, (2009), "No One Type of Intimate Partner Abuse: Exploring Physical and Non-Physical Abuse Among Intimate Partners", Journal of Family Violence, 24: 263-27.

effects of economic abuse on victims of domestic abuse in general indicates that they are more likely to move in more quickly with a new partner out of necessity.[27].

6.10.5. When considering the particulars of Adult 1's lived experience alongside this research, in particular the anecdotal evidence shared by friends and family, the Panel noted Adult 2's reluctance to allow Adult 1 to have any financial link to the property they appeared to share. It was also noted that, despite him having, albeit on paper, a higher income than Adult 1, Adult 2 insisted that Adult 1 was to pay half of any additional costs (e.g., holidays and other socialising). The Panel concluded that:

- With no paper assets in relation to property and a poor credit history, Adult 1 may have felt dependent on Adult 2 for a home for her and her daughter.
- Although Adult 1 was in employment, her working and being able to purchase things for herself and her daughter would have resulted in an outward appearance that she was financially stable. However, this "shielded" the economic abuse she was experiencing from observers, other than the close friends and family that she confided in.
- Adult 1 may have found it too embarrassing to access support in terms of her financial situation.

6.10.6. The Panel also considered if Adult 2's unemployment was a contributory factor to the fatal incident. In doing so, they considered the wording of the letter he addressed to AF 1, which gave a very clear message that his view was that "marriage is for life". The Panel was also supported by research[28] which identified that potential unemployment was a significant risk factor for murder-suicide for males of Adult 2's age and ethnicity facing unemployment, who perpetrated domestic violence and abuse *and* held possessively jealous views.

6.10.7. This risk is significantly heightened where there are significant changes at the point of potential unemployment in the person's social and economic environment. Separation is cited as a vulnerable period that is a significant contributory factor to the risk of murder-suicide when combined with these other factors. The Panel considered this research against how Adult 2 appeared to emotionally deal with his redundancy. AM 2 informed the Panel that "Adult 2 appeared to be coping ok with [his redundancy notice], knew he had support if he wasn't coping about it, but he told me he wasn't worried. He was being interviewed for another role and seemed pretty upbeat about that, but he killed himself before he knew if he was going to be offered the role."

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[27] SEA round table report 2018 https://survivingeconomicabuse.org/economic-abuse/what-is-economic-abuse/

[28] Cheryl L. Meyer, Taronish Irani, Katherine A. Hermes, Betty Yung, 2017, *Explaining Suicide: Patterns, Motivations, and What Notes Reveal*, Academic Press, UK.

Bernie Auchter, 2012, "Murder-Suicide in Families" https://www.ncjrs.gov/pdffiles1/nij/230412.pdf

6.10.8. Whilst it appears Adult 2 was unconcerned about his potential redundancy, the Panel noted that Adult 2 was, in the months preceding the deaths, on the balance of probabilities, experiencing significant losses (namely, his job of some years and relationship). The Panel were mindful statistics also show that 94% of women were murdered by a current or former partner often at the point of, or within 6 months of, a separation where coercion and control were also found to be present within the couple's relationship and noted Adult 1 advising friends of Adult 2 "creeping up on her when she went to the house to collect her belongings".

6.10.9. AF 1, Friends 1 and 2 described how, in the final weeks of his life, Adult 2 was "more accepting of Adult 1 moving on, he seemed resigned to it…we thought his hiding and creeping about the house as odd, but because he was resigned to Adult 1 moving on, we simply thought that was Adult 2 being odd". The Panel also noted that shortly before the deaths, Adult 1 was no longer reliant on the couple sharing the family car, and determined, on the balance of probabilities, this resulted in Adult 2's realisation that he was losing control over Adult 1. This led to the Panel's conclusion that Adult 2, in the final weeks of his life, was, because of those losses, developing a sense of finality that contributed to his decision to end the lives of Adult 1 and himself, and his "hiding and creeping" up on Adult 1 was evidence of Adult 2's decision and planning[29].

6.10.10. The Panel also noted the amount of debt that Adult 2 and Adult 1 had accrued, and how Adult 2, by clearing her credit card debt, may have attempted to ensure Adult 1 would be indebted to him and so remain with him. It also noted that a recurrent theme in the interviews with Adult 2's friends and family were his obsessive/compulsive and frugal tendencies, which were viewed as idiosyncrasies to those that knew the couple, but which had the potential to ensure Adult 2 maintained a level of micromanagement over Adult 1's life[30]. These were referred to as obsessive and compulsive, but there was no evidence to support the widely held view that that Adult 2 was clinically diagnosed with Obsessive Compulsive Disorder[31] linked to this.

6.10.11. The Panel concluded that these behaviours were, on the balance of probabilities, indicators of controlling behaviour that cemented Adult 1's compliance to his demands. This was supported by the information disclosed to Police Officers in 2017, and also the awareness of his friends that the more extreme and violent forms of Adult 2's controlling behaviours were contributing to the breakdown of his relationship with Adult 1. Friend 1 described trying to persuade Adult 2 to access support for his violent and controlling behaviors, but that "I wasn't sure what this support could be – maybe some sort of

[29] Monkton-Smith, 2019, "Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide" https://doi.org/10.1177/1077801219863876 University of Gloucester

[30] Evan Stark (2012), "Looking Beyond Domestic Violence: Policing Coercive Control", Journal of Police Crisis Negotiations, 12:2, 199-217, DOI: 10.1080/15332586.2012.725016

[31] https://www.nhs.uk/conditions/obsessive-compulsive-disorder-ocd/

counselling or anger management…that he could probably access from his GP…".

6.10.12. The Panel were advised that support for perpetrators[32] was available in the Leicester City area, although discussions were ongoing during the review period and extended to the Leicestershire area. This project was not available at the time of couple's separation, and the Panel noted that awareness of the project's eligibility criteria was not well known to the Panel, which reflected a lack of awareness of support for perpetrators in the community.

6.10.13. It was also considered if Adult 1's childhood experiences and her experience of single parenthood from a young age impacted on her resilience and/or vulnerability levels. The anecdotal evidence shared with the Panel did not focus on these factors, even when sensitively probed with family and friends, and so the Panel could not determine if this was indeed the case.

6.11. To establish whether local safeguarding procedures were properly being followed and how effectively local agencies and professionals worked together in relation to domestic abuse

6.11.1. The procedure that was in place in 2017 was that crimes and incidents would have been viewed by an Officer in the Investigation Management Unit (IMU) in order to assess whether the report had been correctly recorded and to identify if there was further evidence to be gathered at that early stage. Crimes would then pass to one of the Force Investigation Units (FIU) to be investigated and Non-Crime vulnerability related incidents would be viewed by the Adult Referral Team. Non-Crime Domestic Incidents were reviewed and filed by a Sergeant.

6.12. To establish if there are any relevant issues affecting public confidence in the protection of people in vulnerable situations, locally

6.12.1. The Home Office has now released guidance in relation to advocacy and support following domestic homicide. Whilst it is accepted it may take some time for this support pathway to be fully embedded, it would appear the pathway is not clear in situations where there has been a murder-suicide where there is no criminal conviction. The guidance states that in the cases of suicide "where there is no criminal conviction, it is outside of the remit of the Homicide Service to support families in these circumstances". It does not say what the arrangements should be where there is a murder-suicide, and a criminal conviction would not be secured as a result. Further clarification from the Home Office would be welcomed to ensure clarity on the arrangements in place to support families impacted by a murder-suicide.

6.13. To establish what relevant policies, protocols and procedures (including risk assessment tools) that were in place during the period of review, if

[32] https://jenkinscentre.org/adult-services The Jenkins Centre is a project in Leicester that works with men and women who are abusive and violent in their relationships to help them change their behaviour. If clients are assessed as suitable they will attend a 24-week group programme that will help them to take responsibility for the abuse towards their partners and change their behaviour.

these were applied and whether current training and policies support professional identification of coercive controlling behaviour

6.13.1. The Panel were able to establish that, since 2007, much activity has been undertaken at a strategic level to ensure tactical and operational activities focus on power, control and prevention messages which seek to identify early signs that a relationship is unhealthy. Since 2013, this has been developed to align with the change in the definition of domestic abuse and includes the need for professionals to identify patterns of abuse. This does not appear to fully support professionals to consider more subtle indicators of abuse by reflecting on the impact of abuse on victims. It also noted that training in relation to coercive control references economic abuse but not in detail. The Panel were aware that the Police had developed a specific training module that focuses on economic abuse, including in more or perceived affluent relationships. It is understood by the Panel that, at the time of this report being authored, SafeLives were developing their DA Matters module that addresses learning in relation to economic abuse. To support local learning from this and other domestic homicide reviews, where economic abuse was a feature, the Police decided that they needed to embed this learning at pace and developed their own Police training module that focused on economic abuse but undertook this development in discussion with SafeLives. The Panel agreed that this development should be available to other professionals.

6.14. To identify any good practice and changes that may have already taken place

6.14.1. General Practitioners responded to each of the reported symptoms and circumstances in a manner supportive of clinical care and best practice, and this included, perhaps unusually, consistency in a named GP seeing Adult 1 at the majority of her appointments.

6.14.2. Police Officers did respond to professional judgement that, in 2017, Adult 1 was at risk of harm and tried to ensure support for her.

6.14.3. Adult 2's employers provided an extensive package of support for all employees facing redundancy via an external company. They also ensured those employees at risk of redundancy knew what support was available to them and included health and wellbeing support. It was confirmed by Adult 2's employer that Adult 2 knew of this support and how to access it, but also that he did not access it.

6.14.4. The Panel also heard that Leicestershire Police have supported 75% of their frontline staff to receive the DA Matters training package. This has been followed by an ongoing training programme to ensure that frontline staff, DA Champions and their supervisors can recognise patterns of abuse and respond appropriately. The Panel were assured that this package has been developed in partnership with the College of Policing and SafeLives. Additionally, the DA Champions who underwent the DA Matters programme have, as part of the ongoing support as DA Champions, also received training from SafeLives to support increased awareness into the impact of economic abuse and how this can be used as a lever to exert coercive control.

6.15. Establish for consideration what may need to change locally and/or nationally to prevent serious harm to victims of domestic abuse in similar circumstances

6.15.1. The Panel identified that further liaison needs to be undertaken with HM Coroner to ensure that, where there is domestic abuse in future deaths that are unlikely to result in Criminal Justice proceedings, the inquest is informed by the findings of the Domestic Homicide Review. This is being addressed locally but discussions with other Domestic Homicide Review Chairs and Overview Report Authors indicates this is national learning. The Home Office is invited to ensure this learning is shared with the Chief Coroner.

6.15.2. The Panel welcomed the clarity on support for families after domestic homicide, provided by the Home Office during the course of this review.

6.15.3. The Panel noted that economic abuse featured strongly in the pattern of coercively controlling behavior perpetrated by Adult 2. It also noted that economic abuse is to be reflected in the definition of domestic abuse, as stated within the 2019 Domestic Abuse Bill. The Panel invite the Home Office to consider how all professionals can be trained to identify economic abuse as part of the pattern of coercive control, and that consideration is given to support victims of abuse living in perceived affluent circumstances.

7. Lessons Identified and Recommendations:

Lesson 1: We need to equip our communities so they can recognise all forms of domestic abuse and know how to share their concerns with agencies that can support victims of abuse.

- **Recommendation 1:** The Community Safety Partnership with partners across Leicester, Leicestershire and Rutland should ensure that awareness raising campaigns are reviewed to ensure they include indicators of increased risk, coercive control, economic abuse and third-party reporting when friends and family are concerned about someone they know is a victim of domestic abuse.

Lesson 2: People living with domestic abuse are likely to confide in people they know and trust. This can include friends, family or people within their community. It is important that our communities have Ambassadors located in the everyday services that we all access.

- **Recommendation 2:** The Community Safety Partnership with partners across Leicester, Leicestershire and Rutland should promote and develop safe access points, where victims of abuse can access advice and support.

Lesson 3: Members of our communities and people who are concerned about their behaviour in their relationships need to know about and be able to access non-criminal justice support to learn about healthy behaviours and be supported to change their behaviour.

- **Recommendation 3:** The Community Safety Partnership with partners across Leicester, Leicestershire and Rutland should undertake a Leicestershire-wide needs and gap analysis to determine current tactical and operational compliance with the Specialist Domestic Violence Court Components 1, to ensure accessible provision of a non-criminal justice perpetrator programme.

Lesson 4: It is important that professionals who respond to reported incidents of domestic violence and abuse remember that, where there is not enough evidence to charge for a physical injury, there may be enough evidence to charge for the new offence of controlling or coercive behaviour.

- **Recommendation 4:** A reminder should be circulated by Leicestershire Police to ensure all Police Officers are aware of the relevant case law in relation to Section 39 assaults and the link to non-violent coercive and/or controlling behaviour.

Lesson 5: This case reminds us that, in line with the anticipated Domestic Abuse Act, professionals may need to be supported to understand economic abuse within interpersonal relationships is wider than financial abuse, and, when it is designed to restrict the freedom of another, it is often experienced within a pattern of coercive and/or controlling behaviour.

- **Recommendation 5:** The Community Safety Partnership with partners across Leicester, Leicestershire and Rutland should develop or commission training in relation to economic abuse within the context of domestic abuse based on the learning from this case.

8. Conclusions

8.1. The Panel concluded there was extremely limited agency involvement with both Adult 1 and Adult 2 and that:

- Professionals were not aware of domestic abuse being Adult 1's lived experience in the months that preceded her murder.

- No opportunity presented to any professional to assess if Adult 1 was at risk of fatality when she separated from Adult 2.

- There was no indication to suggest that Adult 2 had any suicidal tendencies, and so the opportunity for professionals to assess homicidal tendencies as part of the suicidal ideation did not present.

- It was also apparent from discussions with Adult 1's friends and family that they were unsure of what support mechanisms existed or how to access them to gain advice on how to support the couple and Adult 1 would have declined to engage with or access support from professionals.