BIRMINGHAM COMMUNITY SAFETY PARTNERSHIP
WORKING TOGETHER FOR A SAFER CITY

Domestic Homicide Review

Under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of Elizabeth

In September 2017

Report produced for Birmingham Community Safety Partnership by
Paula Harding
Independent Chair and Author
February 2019

GLOSSARY

AAFDA: Advocacy After Fatal Domestic Abuse
CSP: Community Safety Partnership
CCG: Clinical Commissioning Group
CPS: Crown Prosecution Service
DoH: Department of Health
DHR: Domestic Homicide Review
EMIS: Clinical software used in healthcare settings
GP: General Practitioner
IMR: Individual Management Review – reports submitted to review by agencies
IRIS: Identification and Referral to Improve Safety - a general practice-based domestic violence and abuse training support and referral programme

PREFACE

Members of the review panel offer their deepest sympathy to all who have been affected by the death of Elizabeth. They also wish to thank each of the practitioners who have contributed to the review and the bereaved family for their contributions and support throughout the review.

PERSONAL STATEMENTS FROM ELIZABETH'S FAMILY

MY PRECIOUS GIFT

Elizabeth[1] was my darling, long awaited first born, always known to me as my precious gift. Elizabeth was the best big sister to her 2 younger sisters and an amazing daughter. My quiet shy little girl had grown into an amazing treasured, beautiful, loving and caring young lady, her confidence growing every day.
Elizabeth was loved by anyone who ever knew her. She had an impact on so many people. Right from the start, at school she quietly shone, a keen member of the Guiding World, becoming a young leader, and only leaving when she began her lifelong passion to work with tiny babies at the Birmingham Women's Hospital as a nursery nurse. She took great pride in her work and helped countless new-born babies and their mums; this has been echoed by the amount of tributes I have received from the mums Elizabeth cared for.
This extremely tragic loss of my wonderful baby has left a huge hole in not only my life but in all the people who knew her. The beautiful girl who smiled with her eyes, Elizabeth was so much loved, not only by her parents but her sisters and their partners, her grandparents, aunties, uncles, cousins, numerous lifelong friends and her hospital family. Everyone so proud to have loved her.
We are all devastated by her loss. A part of me died with her on that awful day. a part that can never be repaired. My beautiful clever, elegant, reliable, loving, funny baby.
The truth is, she was not just my precious gift but a precious gift to all who had the honour of knowing her: everything good you could say about one person; adorable and beautiful inside and out that was, My Precious Gift.

OUR SISTER

Elizabeth never took life too seriously. She had a kind, young, fun heart. She would still race you to get the front seat of the car, she would hide behind the living room door to jump out at you.

She was a great shopping partner, and would find ridiculous outfits to try on, once convincing a shop attendant in Debenhams that we had a very important ball to go to, who then went on to find us several dresses to try on in their personal shopper dressing rooms - we had no intention of buying anything.

Elizabeth was the biggest Christmas fan and would always be the first to message us all if ever it started to snow.

She was funny, often without intending to be – and if she had a tale to tell, they would go on forever, in every direction before we got to the end of it.

She also had <u>no</u> boundaries - somehow, she always found a way for conversations at dinner to come back to the bodily fluids that had come from her hospital experiences!

[1] pseudonym

We always admired the work she did taking care of poorly babies born with endless lists of health conditions. I'd tell her often that I don't know how she does it, but Elizabeth was born to do the job she did.

She was always working so she missed out on some birthdays, family nights out and Christmas dinners, but we don't resent that one bit. She worked so hard because she cared so much and she loved her job - it was a huge part of her.

Elizabeth was never a big drinker, and she would feel out of place in a club - but she did like being out with her friends, and would organise fun things to do with them, and days out with their children.

Elizabeth was brilliant at baking and liked trying out new recipes. We'd always ask her to bring something to parties, which she would gladly do, and because she was notoriously running late, she'd turn up with warm cupcakes that still needed icing!

You could talk openly and honestly about anything to her, she was completely understanding and sympathetic, while at the same time being brutally honest - which is one of the many things we will miss.

Elizabeth was truly beautiful inside and out, and I know it's a cliché but we have lost a huge part of ourselves. We are a trio: losing Elizabeth has changed our family forever, along with hundreds of others who knew and loved her.

We're so, so proud to call her our big sister.

THE REVIEW

As close as we are as a family, we had no idea that she was being coercively controlled. We firmly believe that Elizabeth herself didn't associate any of his behavior with this kind of relationship. It is terrifying to think that nobody, not even Elizabeth, had any idea of what a dangerous situation she was in until it was too late.

It is for this reason that we have contributed to this report in the hope that it helps to enforce even small changes that might make someone think twice or seek help if something about their relationship doesn't feel quite right.

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1. INTRODUCTION

1.1. Aim and Purpose of a domestic homicide review

1. Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom she was related or with whom she was or had been in an intimate personal relationship or (b) member of the same household as herself; with a view to identifying the lessons to be learnt from the death.

2. The purpose of a 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 co-ordinated 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" (Multi-Agency Statutory Guidance 2016, para 7)

3. As well as examining agency responses, statutory guidance requires reviews to be professionally curious and find the "trail of abuse". The narrative of each review should "articulate the life through the eyes of the victim…The key is situating the review in the home, family and community of the victim and exploring everything with an open mind". (*Multi-Agency Statutory Guidance 2016, paras 8 and 9*)

4. Hence, the key purpose for undertaking a Domestic Homicide Review is to enable lessons to be learned where a person is killed as a result of domestic violence, abuse or neglect. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2. Summary of the circumstances leading to the review

5. This Domestic Homicide Review concerns the death of Elizabeth, who, at the age of 32, was killed by her husband, aged 30, who then went on to kill himself.

6. The coroner has determined that Elizabeth's death was unlawful killing and the perpetrator's death was suicide.

1.3. Timescales

7. Birmingham Community Safety Partnership was notified of the death on in September 2017 and the decision to undertake a review was made in February 2018. There had been an initial delay in commencing the review due to structural changes in the Partnership, but having commenced, the review then proceeded in a timely manner and was concluded in February 2019.

1.4. Confidentiality

8. The bereaved family were consulted on whether they wished us to use a pseudonym for the victim and chose the name Elizabeth.

9. During the course of this review, the details have remained confidential, available only to participating professionals and their direct line management. This report has sought to extract sufficient detail from the victim's narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

2. TERMS OF REFERENCE

2.1. Methodology and Engagement with Family

10. The Home Office was notified on 07.02.18 of the decision to hold a domestic homicide review. All local agencies were notified of the death and were promptly asked to examine their records to establish if they had been approached by or provided any services to the family and to secure records if there had been any involvement. Arrangements were made to appoint the Independent Domestic Homicide Review Chair and Author, Paula Harding, and agree the make-up of the multi-agency review panel.

11. The victim's family were notified of the Domestic Homicide Review, invited to engage and provided with details of specialist advocacy support. Elizabeth's close family have all engaged with the review and each have been supported through the process by Advocacy After Fatal Domestic Abuse (AAFDA). In view of ongoing legal disputes of a sensitive and unexpected nature between the two families, a decision was made not to engage with the perpetrator's family.

12. After meetings had been held with Elizabeth's family, the Chair and review panel proceeded to draft terms of reference and key lines of enquiry for the review and checked these with the family, adding the questions that they had raised.

13. The panel met on three occasions. The few agencies that had any involvement were asked to provide a chronology of their contacts with the victim and the perpetrator as well as information and analysis of their involvement. Panel members were able to discuss the progress of the review reports and request further clarification and additional material, where needed.

14. The hospital where Elizabeth had been employed, joined the panel and provided information to support the review. It was hoped that a meeting could be arranged with Elizabeth's work colleagues, but this did not transpire as colleagues felt that they did not have anything further to add to the information that they had already shared.

15. The Chair went on to update the family and meet with various members of the family at various points during the review. At the end of the review, the family were provided with the opportunity to read and digest the draft Overview Report and then meet with the Chair to discuss its findings. They helpfully made insightful comments which have been incorporated into this final draft.

16. All panel meetings and meetings with the family were minuted and all actions agreed for the panel have been tracked and signed off. The draft Overview Report was presented to the Partnership's Domestic Homicide Review Steering Group, who provide an internal quality assurance role for the Partnership, in September 2018. The Overview Report was endorsed by the Community Safety Partnership on 6th February 2019 prior to submission to the Home Office.

17. All family members will be notified before publication of the report and engagement and support will be offered by the Partnership again at this time.

2.2. Independent Chair and Overview Author

18. The Independent Chair and Overview Author is Paula Harding, who has compiled the Overview Report, the Executive Summary and coordinated the integrated action plan. Paula Harding has over twenty-five years' experience of working in domestic violence and related services. Her senior local authority and third sector experience has spanned working in refuge, advice and outreach services; management of front-line services; training and development; policy formation and strategic commissioning. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic violence and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide*

Reviews in 2013. She has also completed the on-line training provided by the Home Office: *Conducting a Homicide Review*[2].

19. More than 18 months previously, Paula Harding worked for Birmingham City Council as the strategic and commissioning lead for Violence Against Women and Domestic Homicide Reviews in the city. However, beyond chairing Domestic Homicide Reviews, Paula Harding has not been employed by any of the statutory agencies of Birmingham Community Safety Partnership or agencies affected by this review, since. The report will go on to analyse the local area's preventative work and it can be confirmed that the Independent Chair and Author was not involved in this aspect of service delivery referred to within the city during the period under scope of this review.

2.2. Members of the Review Panel

20. Multi-agency membership of this review panel was determined by the Independent Chair and consisted of senior managers and/or designated professionals from the key statutory agencies. With the exception of the representative from the hospital who employed Elizabeth, panel members had not had any direct contact or management involvement with the victim, and they were not the authors of information reports provided to the review.

21. Birmingham and Solihull Women's Aid provided particular expertise on gendered domestic abuse and the broader 'victim's perspective' to the panel. Wider matters of diversity and equality were considered, but not considered directly relevant to membership of the panel.

22. The review panel members were:

- Paula Harding, Independent Chair
- Amandeep Sanghera, Detective Inspector, West Midlands Police
- Anne McGarry, Lead Nurse for Safeguarding Adults and Mental Capacity Act, Birmingham Community Healthcare Trust
- Gemma Wragg, Refuge Manager, Birmingham & Solihull Women's Aid
- Jacqui Oldbury, Safeguarding Practice Learning Manager, Birmingham Children's Trust
- Joanne Mardell, Named Midwife/ Safeguarding Team Manager, Birmingham Women's and Children's NHS Foundation Trust
- Melanie Homer, Designated Nurse for Safeguarding Adults and Children, Birmingham and Solihull Clinical Commissioning Group
- Ruth Levesley, Chief Executive, Relate Birmingham
- Steven Perry, Deputy Head of Birmingham Delivery Unit, National Probation Service

[2] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

2.3. Scope and Key Lines of Enquiry

23. The review sought to address both the 'circumstances of a particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:
    - What can be established about the nature of the victim and her husband's relationship?
    - What can be established about how the victim understood her experiences and what prevented her from seeking help?
    - How might agencies have identified the existence of domestic abuse from other issues presented to them and how might they have responded?
    - How were staff supported to respond to identify and respond to issues of domestic abuse, safeguarding and public protection?
    - How is information and awareness raising about domestic abuse reaching Birmingham's communities?

24. Three agencies were asked to provide chronologies, information reports or Individual Management Reviews, dependent upon their degree of involvement:
    - Relate Birmingham in respect of counselling services provided in the months before Elizabeth's death.
    - Birmingham and Solihull Clinical Commissioning Group in respect of the GP practice concerned.
    - Birmingham Women and Children's Hospital in respect of their role as an employer.

25. Specific questions directed to each of these agencies feature later in the report when their responses are considered in depth.

2.4. Time Period

26. The panel agreed that the review should focus on the contact that agencies had with the couple between 2011, when the couple first met, and the date of the death. Although the panel were open to any significant information which might have come to light during the review outside the set timeframe, none was revealed.

2.5. Agencies without contact

27. The following agencies were contacted but confirmed that the couple had not been known to them or that their contact was not relevant to this review:

- Birmingham and Solihull Mental Health NHS Foundation Trust
- Birmingham Children's Trust
- Birmingham City Council Adult, Legal, Public Health and Housing Services
- Birmingham Community Healthcare Trust
- Birmingham domestic violence and sexual assault services (14 separate third sector organisations)
- Birmingham substance misuse and addiction services (through Public Health)
- National Probation Service
- Staffordshire and West Midlands Probation Service
- University Hospitals Birmingham NHS Foundation Trust
- West Midlands Ambulance Service
- West Midlands Police

2.6. The definition of domestic violence and abuse

28. The Government's definition of domestic violence and abuse, which sets the standard for agencies nationally was applied to this review:
"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:
- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is an 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."[3]

29. The inclusion of controlling and coercive behavior within this most recent definition is particularly relevant to this review. Moreover, prior to publication of this report, the Domestic Abuse Bill 2020 was making its way through Parliament. If enacted, it would provide a legal definition of domestic abuse and one which incorporates economic abuse, which is particularly relevant to this case. Whist yet to be defined in law, economic abuse is understood to include, "behaviours that interfere with the ability to acquire, use and maintain economic resources" (Sharp-Jeffs, 2017:6).

[3] https://www.gov.uk/guidance/domestic-violence-and-abuse

2.7. Parallel Reviews

30. Beyond the inquests, the review panel was not made aware of any parallel proceedings.

2.8. Equality and Diversity

31. The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. In this case it was considered that the victim's sex was relevant to the review. In the three years preceding Elizabeth's murder, seventy per cent of victims of domestic homicides were female and in the year of her death, eighty-three per cent of victims reporting coercive control to the police[4] were female (Office for National Statistics, 2017).

2.9. Dissemination

32. The following recipients will receive a copy of the completed report:
- The victim's family
- The perpetrator's family
- Agencies participating in the review
- Agencies of Birmingham Community Safety Partnership
- Office of the Police and Crime Commissioner

33. The report will be published on the Birmingham Community Safety Partnership website http://birminghamcsp.org.uk/

[4] 83% of victims were female where the victim's gender had been recorded. Gender had not been recorded in 22% of cases.

3. BACKGROUND INFORMATION

3.1. The victim's family history

34. In order to protect the identity of the victim and the family, their identities have been anonymised and the victim is referred to with the pseudonym, Elizabeth. She was aged 32 at the time of her death and the perpetrator, her husband, was aged 30.

35. Elizabeth came from a very close-knit family and had two sisters. In most regards, she appeared to confide in her parents and sisters freely.

36. She had worked as a neo-natal nursery nurse at a local hospital since she was 19. This was a small, specialist and supportive unit and Elizabeth had a strong friendship group at work. At a recent memorial held at the hospital, it was revealed that she was very well respected in her role and senior clinicians spoke about relying upon her advice regarding the babies that she looked after.

37. Despite the fact that the couple were buying their own home together, the perpetrator had not worked for several years. Shortly before her death, Elizabeth had found out that her husband relied upon a monthly allowance, which was equivalent to a wage, from his parents. The perpetrator aspired to be a personal trainer. Whilst he had previously worked irregularly as a doorman serving a local entertainment venue, he had become reluctant to do work that did not inspire him.

38. The perpetrator was an avid player of computer games and had only one friend who lived in another city, who he had met through gaming. His relationship with his family has not been made clear to the review.

3.2. The homicide

39. As the perpetrator had gone on to take his own life, a criminal investigation was not undertaken in this case. However, West Midlands Police undertook an investigation on behalf of the Coroner and provided the review with the following details:

40. Elizabeth attended Birmingham Women's Hospital for a night shift on Sunday 24th September, leaving some time after her shift ended on the Monday morning. Between 10.00 hours and 14.30 hours, she was subject to a single stab wound whilst in bed asleep that day.

41. Shortly after midnight, in the early hours of Tuesday 26th September 2017, there was a 999 call to the Ambulance Service from the home of the perpetrator's parents. The family had found the perpetrator deceased in the back garden having doused himself with petrol and set himself alight.

42. Shortly afterwards, West Midlands Police received a call from Elizabeth's mother who had been to her daughter's home address and found her daughter in her bedroom. She was already deceased and a post-mortem later confirmed that the cause of death

was a stab wound to the neck. There was evidence that she had been there for several hours.

43. The investigation revealed that, having killed Elizabeth, the perpetrator drove to a petrol station, filled a petrol can and drove to his parent's home, approximately 20 miles away. He sent an apologetic text to his brother, cryptically indicating his intention to kill himself and wrote a suicide note in which he gave instruction that Elizabeth's cats were not to be taken by her family.

44. He left out his bankcards in the spare bedroom where he had been staying, alongside an empty bottle of whisky and proceeded to set fire to himself in the garden. His brother, responding to the text message, called for emergency services and attempted to save his brother, who was already on fire, but his brother died shortly afterwards.

45. When the Police examined Elizabeth's mobile phone, they found recent messages demonstrating that Elizabeth had told her husband that she no longer loved him and wanted a divorce. His responses had been intense, clearly wanting the marriage to continue. Text messages of this nature had continued until the day of her death. One message inferred that he could not live without her.

4. CHRONOLOGY

46. The couple had very little contact with agencies prior to their deaths. The commentary that follows is therefore based primarily on information provided by members of Elizabeth's family, supplemented by brief agency records, information reports and one Individual Management Review. They represent the Independent Chair's view of significant information and events about the victim.

47. Elizabeth met the perpetrator in 2011 through an internet-dating site. The couple moved in together a year later in 2012 and married in May 2014.

48. The perpetrator was described as being flamboyant in his emotional gestures to Elizabeth. He took her on extravagant first dates; made plans to propose to her in a hot air balloon and wanted a big wedding, which he controlled to the smallest detail.

49. In the intervening years, Elizabeth's family became aware that he was controlling and manipulative in the relationship. They thought him to be unhappy with the closeness of Elizabeth's relationship with them and Elizabeth appeared to have lost confidence through this period.

50. Around the end of 2015, it transpired that Elizabeth had written a letter to the perpetrator in which she questioned her husband about why he treated her so badly. The letter refers to him undermining her and calling her names and she questions how he could love her when he put her down so badly. She spoke of how unhappy it made her feel. It is not known whether the perpetrator received or read the letter, as it had been found in the recycling bin after Elizabeth's death.

51. At a family wedding in November 2016, the perpetrator was aggressive to members of the family and this was the first time, one year before her death, that Elizabeth had told anyone that she was unhappy with the relationship.

52. By January 2017, Elizabeth had started to disclose to her family more about her relationship. She spoke about "keeping the peace" whilst no longer pandering to her husband's demands.

53. In the period that followed Elizabeth started going out more, seeing more of her family and regaining some of her lost confidence. At the same time as Elizabeth's confidence was growing, her husband had become very jealous and suspicious of how close family and friends were becoming and he appeared to feel left out. He had even threatened to cut his wrists if Elizabeth ever left him. Elizabeth was reportedly very concerned about what he might do to himself if she were to leave.

54. The perpetrator pressured Elizabeth to seek couple counselling with him through Relate. He made the first approach to Relate Birmingham in June 2017 and met with a counsellor for two individual sessions, the first of which was for the purpose of assessment and the second for individual counselling. During these sessions, he described the difficulties in the relationship stemming from communication problems and the problems that he had with his wife's family.

55. On 17th July 2017, Elizabeth and her husband had an assessment session with Relate followed by a couple counselling session on 14th September.

56. The following weekend of the 16th and 17th September, the couple had planned a weekend away in Brighton. During their stay, Elizabeth told her husband that she wanted a divorce and the couple returned home early. He said that he would pack and move back to his parents. Elizabeth was at work for the rest of the week and the perpetrator was moving his possessions out of the house so slowly that it led to an argument between them.

57. On 21st September 2017, they attended their last couple counselling session with Relate. In this session, Elizabeth said that the relationship was over and they discussed plans for Elizabeth to stay in the home and for the perpetrator to go to live with his brother, from where he would be able to go to the gym, which was important to him. The counsellor made it clear that either of the couple could come back for help with separation. They said that they would have some time to digest what had happened and then may come back. The case was then closed.

58. During this period, the perpetrator began texting her constantly at work and would try to start arguments as Elizabeth was leaving for work. If she was on a night shift, he would send long texts all through the night. At the same time, Elizabeth's colleagues at work had been sent aggressive Facebook messages from the perpetrator and receiving these prompted them to offer Elizabeth somewhere else to stay but she declined, again saying that she thought he would never harm her.

59. Elizabeth was killed during the daytime on Monday 25th September 2017. That evening, before killing himself, the perpetrator posted concerning comments on Facebook which worried Elizabeth's family. On Facebook, he talked about how he had been let down and how Elizabeth had become cold towards him. These comments prompted Elizabeth's mother and sister to call to see her and find her deceased.

5. OVERVIEW OF AGENCY INVOLVEMENT

60. This section considers the Individual Management Review and Information Reports completed by individual agencies and the outcomes of discussions with the review panel concerning improvements to services in the future.

5.1 Relate Birmingham

61. Relate Birmingham were asked to complete an IMR in respect of their involvement with the couple in 2017 with specific questions around:

- How staff were supported to respond to issues of domestic abuse, safeguarding and public protection.
- Domestic abuse policies and procedures.
- Requirements for supervision around domestic abuse.
- Specialist domestic abuse training required for staff.
- Whether staff identified domestic abuse within this relationship and if so, how they responded?
- If domestic abuse was not known, how might staff have identified the existence of domestic abuse from other issues presented to them?
- Identifying areas of good practice, lessons learnt and recommendations for their own organisation.

62. Relate Birmingham is a local, independent charity and member of the national Relate Federation. They provide a range of relationship support services including counselling for individuals and couples. As they estimate that up to twenty-four per cent of their clients are experiencing or perpetrating domestic abuse, the service has a detailed domestic abuse policy. The policy provides rationales and procedures to support staff to identify domestic abuse across a spectrum of behaviours and work appropriately with clients when domestic abuse has been disclosed or is suspected.

63. In Relate, all staff must complete mandatory internal training on domestic abuse and all counsellors and clinical supervisors must complete additional mandatory training in domestic abuse assessment, individual structured interviews as well as various courses in mental health and safeguarding.

64. Within this context and model of working, two intake assessments were conducted:

one with the perpetrator on his own, as he initially had individual counselling, and one with the couple. At these assessments, the counsellor sought to identify potential risks or any contraindications for counselling as well as agreeing the focus of the work to follow.

65. It was not considered unusual for a man to approach Relate and have individual sessions. Relate described how they were accustomed to witnessing strong feelings and it is often the case that one person is more committed to the relationship than the other. Having undertaken an initial assessment and one further counselling session, his individual case was closed as the perpetrator said his wife would attend couple counselling with him.

66. Reflecting upon their contact with the couple, Relate Birmingham found nothing remarkable in the couple's presentations. Domestic abuse was not identified as a feature of the relationship between Elizabeth and her husband. Different counsellors worked with the perpetrator individually and with the two as a couple. In both cases, there were no presenting issues or comments made that raised concerns for the counsellors who themselves were alert to the need to respond specifically to domestic abuse or other areas of concern and risk.

67. The couple counsellor recalled describing the perpetrator as very "intense" in his emotions and feeling unsettled after their final session. As a result, the counsellor had discussed these feelings at individual and group supervision where it was concluded that the counsellor's feelings stemmed from a desire to help the perpetrator who was clearly struggling with the circumstances. Indeed, given the circumstances, this intensity was not considered particularly unusual and not, in itself, an indicator of potential domestic abuse.

68. Relate Birmingham noted that the perpetrator had been seen on his own because of receiving individual counselling. However, within the current couple counselling process, Elizabeth had not had the same opportunity to be seen on her own. As a result of their reflections in this case, Relate Birmingham have decided to change their local procedures to ensure that all couples in the future are offered an individual session with a counsellor as early in the couple counselling process as possible. This action will make local procedures in line with best practice guidance from Relate National.

69. Whilst all staff at Relate Birmingham had received domestic abuse training, this did not necessarily involve training on coercive control. The need for all counselling staff and supervisors to be trained in identification and response to coercive control has become a recommendation for the service.

70. Membership of the Relate Federation means that Relate Birmingham both adheres to national policy and practice and gains support from the national body. Relate National began an extensive review of its approach to domestic abuse at the end of 2017. The review concludes in the autumn of 2018 and will result in a revised domestic abuse policy, protocols and procedures. As a result of this review, Relate Birmingham are

making recommendations to their National Federation that new procedures should be introduced to ensure that direct questions about domestic abuse were asked routinely as part of all individual sessions. This would give individuals an opportunity to speak privately with the counsellor if they wished at that time. It would also enable the counsellor to introduce the topic of domestic abuse safely and not rely upon a victim's self-disclosure to prompt discussion. This is a matter for national attention as it would involve introducing new procedures into the counselling process to ensure that direct questioning can be done safely and accompanied by an appropriate care pathway.

5.2 GP Practice

71. Birmingham and Solihull Clinical Commissioning Group completed an information report on behalf of the GP practice concerned and were asked specifically to detail:
- Whether the GP Practice was aware of any domestic abuse, coercive control or discord in the relationship?
- Whether any routine medical enquiries presented by Elizabeth did, or could have, involved asking about domestic abuse?
- Whether the GP Practice has a domestic abuse policy; systematically trains its staff in responding to domestic abuse or is part of the IRIS Programme.

72. Over the six-year period covered by this review, the perpetrator was seen on around a dozen times for routine medical appointments, none of which related to mental health. However, on at least two occasions he sought growth hormones to aid his body building.

73. Elizabeth had twenty-four consultations at the same GP practice over the same period covered. Four of these consultations were with a GP and the rest with various practice nurses and all concerned routine medical issues consistent with her age.

74. None of the consultations involved injury and no disclosures were made about domestic abuse. None of these routine issues would have given rise to selective routine enquiry in domestic abuse under the current domestic abuse guidance for primary care. For example, the Practice had been asked to consider whether opportunities had been missed for routine enquiry in domestic abuse at times when contraception advice or smears were provided. Guidance endorsed by the Royal College of General Practitioners (2012) does not promote routine enquiry unless indicators of abuse are present and the professional curiosity of the individual practitioner is raised.

75. Nonetheless, the GP practice concerned did not have a domestic abuse policy and did not train its staff in responding to domestic abuse, both of which are described as best practice by the Department of Health (2017) and NICE (2016). In order to achieve these improvements, the Clinical Commissioning Group has recommended that the GP practice concerned adopts the domestic abuse programme that is available to them and becomes an 'IRIS domestic violence aware practice'.

76. Information was provided by the national Identification and Referral to Improve Safety (IRIS) Programme Manager about the scheme and prompts for clinical enquiry. The IRIS Programme is a general practice-based, domestic abuse, training, support and referral programme, which seeks to provide a skilled, care pathway for domestic abuse. The programme recruits a clinical champion from each practice and delivers training, electronic prompts for clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. In Birmingham, funding has been made available for rollout of the IRIS Programme across Birmingham's GP practices by March 2019.

77. Although the funding and infrastructure is available, each GP practice has to volunteer to be involved in IRIS as it is not a mandatory part of national contracts for General Practice. In order to achieve the status of becoming an 'IRIS domestic violence aware practice', seventy-five per cent of clinicians must have received training in domestic abuse. Elizabeth's GP practice has agreed to adopt IRIS.

5.3 Birmingham Women's and Children's NHS Foundation Trust

78. Elizabeth had been employed at Birmingham Women's Hospital[5] since 2004 and worked in a small team, which was described by her employer as close-knit. She had close relationships with her work colleagues and it was later discovered that she had disclosed concerns regarding her husband's behaviour to them. She had told them that her husband was controlling and had made derogatory comments towards her but said that he had not been verbally aggressive or threatening. The perpetrator's aggression had also been aimed at them directly in recent times as he had sent them abusive Facebook messages. As a result, Elizabeth's work colleagues offered support and a place to stay if she needed one. However, Elizabeth declined and reportedly said that she was safe, as he would never hurt her.

79. Birmingham Women's Hospital were asked to provide an information report detailing:

- Whether any staff with managerial responsibilities were aware of the domestic abuse that Elizabeth was experiencing and if so, how did they respond?
- What opportunities did the Hospital have as an employer, in enabling Elizabeth to gain support?

80. Birmingham Women's and Children's NHS Foundation Trust, to which the Hospital now belongs, found that there had been no disclosures to supervisors or managers about Elizabeth's experiences. Nor did managers have any cause for concern over Elizabeth's work that might indicate domestic abuse. Elizabeth had no sudden, unexpected absences or lateness. The Department of Health recognises that seventy-five per cent of domestic abuse victims are targeted at work through telephone calls and emails

[5] Birmingham Women's Hospital has since become part of Birmingham Women's and Children's NHS Foundation Trust

(2017, p. 25). For Elizabeth, there were no such indicators that she had been targeted at work in any way by her husband.

81. Throughout the period of Elizabeth's marriage, the Hospital had provided a free and confidential staff support and counselling service where staff members can self-refer but there is no record of Elizabeth approaching them.

82. The Women's Hospital had done much work during these years to improve their maternity services approach to women experiencing domestic abuse. Routine enquiry about domestic abuse was a fundamental part of the offer to pregnant women and posters and sources of help were systematically displayed across the hospital.

83. More recently, the Trust has worked to finalise a new Staff Domestic Abuse Policy, which will strengthen their response to employees experiencing domestic abuse. The new policy seeks to support managers to facilitate disclosures of domestic abuse and signpost victims to external specialist agencies for further support.

84. The Trust advised that the new workplace policy would be communicated to all staff and managers and it will ask staff to remember their colleagues as well as their service users. In this way, it is hoped that more staff members will feel able to identify their experiences of domestic abuse and feel confident in seeking support.

85. The Trust will consider auditing improvements in the management of staff disclosures and the support offered to monitor the effectiveness of the new policy. Birmingham and Solihull Clinical Commissioning Group has also agreed to monitor the effectiveness of this new policy and approach.

6. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS

86. Whilst the couple's contact with agencies was light and mostly unrelated to Elizabeth's experiences of abuse, some distinct themes have emerged for this domestic homicide review:

6.1 Indicators of Domestic Abuse

87. The review heard how Elizabeth had told family and friends that her husband was controlling but would never harm her. However, a letter that she wrote to her husband indicates that she feared, at some juncture, that he might harm her and therefore she must have felt the need to minimise these fears to those that she cared for.

88. Minimisation of abuse, to oneself or others, is a common ally of domestic abuse. It can happen for many reasons including fear, protection of others, self-blame, misunderstanding and denial and will often serve as a powerful coping mechanism for those experiencing domestic abuse (Stark, 2007).

89. It is not possible to determine with any certainty whether Elizabeth was scared of her husband. However, with the benefit of hindsight, it is possible to see a broader picture of domestic abuse than any of her family or friends will have been aware of at the time.

90. When the couple's relationship began, the perpetrator had been flamboyant in his emotional gestures and gifts to Elizabeth. He would later begrudge having given them and remind Elizabeth of how much he had spent on her. He would buy her expensive make-up then hide it when she was going out, questioning why he should buy her nice things only to look nice for other men. He even hid her engagement ring from her. What might have appeared to be romantic gestures of affection became techniques for arousing confusing emotions such as gratitude or guilt. Concealing her make-up and engagement ring could also be seen as forms of economic abuse.

91. Elizabeth's family reflected that the perpetrator had been monitoring Elizabeth's behaviour within the relationship and making seemingly innocent incidents appear more sinister. This is perhaps a good example of the relationship between stalking and coercive control. Perpetrators of coercive control will normally use surveillance and stalking to maintain their control over their victims (Stark, 2009).

92. Campbell et al (2003) found the most frequent behaviours identified preceding an intimate partner homicide were following and spying, and they further report that women who reported being followed or spied on, or women who reported that the perpetrator was trying to communicate with them against their will, had nearly a twofold increase in the risk of becoming a homicide victim.

93. After Elizabeth had indicated that she wanted the relationship to end, the perpetrator's text messaging to her whilst she was at work became constant. This kind of escalation is also consistent with an escalation of risk for the victim. Indeed, research has shown that stalking behaviours have been present in 94 per cent of domestic homicides (Monckton-Smith, Szymanska & Haille, 2017)

94. The closeness of Elizabeth to her family had been a source of discontent to her husband and he often disrupted the family occasions that he was involved in, requiring Elizabeth to attend to his needs. He generally avoided family occasions but on the times that he did, he either became angry and aggressive with family members or awkward and clingy with Elizabeth. When Elizabeth went away with her family or friends, such as for her 'hen weekend', it was not uncommon for him to make her feel guilty for having left him alone. In this way, the perpetrator could be seen to have attempted to isolate Elizabeth from her family which, whilst not successful, did contribute to some disruption to her family relationships.

95. Elizabeth's letter to her husband confirms that he persistently undermined her, called her offensive names and was cruel and that this impacted upon her self-confidence. Indeed, Elizabeth's mother spoke of 'getting her Elizabeth back', when her daughter's

confidence began to improve. This itself indicates some of the longer-term impact that the perpetrator's behaviour must have had on her daughter.

96. As Elizabeth's confidence grew, her husband had threatened to cut his wrists if Elizabeth ever left him and this appeared to deeply concern Elizabeth. Threats such as these are often profound in the way that they control an individual's behaviour and limit a domestic abuse victim's opportunity to be free. These threats need to be viewed alongside his attempts to isolate Elizabeth; his persistent undermining of her and calling her names; his occasional indulgences followed by recriminations and his jealousy. Each of these create the framework for coercive control (Weiner, 2017). The degree to which Elizabeth felt controlled is not known, although she maintained her close family ties, strong work friendships and maintained an impeccable work reputation throughout the time that she knew her husband.

97. The suddenness of the perpetrator' abuse escalating with such ferocity was, of course, profoundly shocking to all concerned. However, the fact that he murdered Elizabeth when she was seeking to end the relationship was consistent with the majority of domestic abuse-related serious harm and deaths, both locally and nationally. In Birmingham, the majority of women killed through domestic abuse since 2011 have been killed when they were trying to end the relationship.

98. Recent separation is already a key factor for agencies to consider when they are assessing the risk of serious harm from domestic abuse[6]. Although no agencies were aware of domestic abuse in the relationship, this murder adds to the national picture that the most dangerous time for women, and children, is when they leave an abusive relationship (Humphreys and Thiara, 2002). Most importantly, the narrative of Elizabeth's murder should be widely heard so that the wider population, as well as agencies, can understand how quickly stalking and coercive control can escalate to such fateful consequences.

6.2 Direct Questioning

99. This review has identified missed opportunities in couple counselling to speak with individuals on their own and be able to ask direct questions about domestic abuse. In this case, there is nothing to say that had she been asked, that Elizabeth would have disclosed the degree of control that her husband sought to maintain in their relationship.

100. Introducing the issue of domestic abuse through direct questioning has been seen in health and therapeutic settings to have the added advantages of breaking the stigma

[6] The Domestic Abuse, Stalking and Harassment Risk Indicator (DASH) includes separation as one of 24 indicators of vulnerability to high risk of serious harm or death. DASH is routinely used by the police and many agencies and is available through Safe Lives, a second tier domestic abuse organisation, at http://www.safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL_1.pdf

of domestic abuse. Indeed, "women who have been abused say they were glad when a health practitioner asked them about their relationships." (Department of Health, 2017, p.34)

101. In working with couples, the need to identify domestic abuse at the earliest opportunity is all the greater. Where domestic abuse is not identified and work with a couple continues, there is a danger of increasing the risk to someone experiencing domestic abuse. West Midlands Domestic Violence and Abuse Standards provide examples of 'couple-work' which can put victims at risk and recognise that it can "place victims in an environment where they cannot speak openly for fear of punishment…[or]…collude with the abuser by sharing responsibility for change with the victim" (2015, p.11)

Recommendation 1: Safe Therapeutic Work
Birmingham Community Safety Partnership should seek assurance from its partner agencies, in keeping with West Midlands Domestic Violence and Abuse Standards, that they do not engage in, or commission, unsafe work with couples where there is domestic abuse. This requires agencies having robust mechanisms for screening and identifying domestic abuse, enabling safe disclosure and finding safe ways to work with the individuals concerned.

Relate Federation to ensure that new procedures require direct questions about domestic abuse to be asked routinely as part of all individual sessions.

Home Office to consider the development of guidance for multi-agency practitioners on safe practice in work with couples where there is domestic abuse (as recommended by the Home Office Quality Assurance Panel)

6.3 The Workplace

102. This review has highlighted the significance of the workplace for victims of domestic abuse. Work can be both a sanctuary from abuse and an opportunity for effective help seeking.

103. Elizabeth clearly confided in her friends at work and as more became known about her husband's behaviour, they offered her increased support and somewhere safe to stay.

104. We have seen that Elizabeth's place of work has recently introduced a staff domestic abuse policy into their newly amalgamated NHS Trust. At the same time, the recent Birmingham Domestic Abuse Prevention Strategy 2018-2023 makes clear that it intends to promote the adoption of workplace domestic abuse policies across the city. The learning from this domestic homicide review can provide a powerful narrative to help with the encouragement to adopt workplace policies amongst public and private employers in the city.

Recommendation 2: The Workplace Birmingham Community Safety Partnership should set the standard and ensure that all agencies in the city have up-to-date, robust workplace domestic abuse policies that enable employers and colleagues to both support victims and deal with perpetrators of domestic abuse in their workforce.
The Home Office should provide guidance for employers on workplace domestic abuse policies that enable employers and colleagues to both support victims and deal with perpetrators of domestic abuse in their workforce (as recommended by the Home Office Quality Assurance Panel).

105. The National Probation Service representative on the panel has recommended that their historic workplace domestic abuse policy, in operation when they were the regional Staffordshire and West Midlands Probation Trust, be adopted for the entire national workforce. This endorsement at the national level is now in the process of being provided.

106. The review noted advancements in employer's responses to domestic abuse being made through the Employer's Initiative on Domestic Abuse[7] as well as wider guidance to employers by agencies such as Public Health and Business in the Community (2019).

6.4 Public Awareness

107. Besides Elizabeth, no-one had the entire picture of Elizabeth's life with her husband or the chance to label her experiences as domestic abuse. It is unclear whether Elizabeth understood her experiences as domestic abuse, herself.

108. It seems that there is much still to be done to inform public attitudes about the nature of domestic abuse and how coercive control is an integral element of this abuse. Likewise, much needs to be done to change public attitudes and behaviours about domestic abuse. Without exception, Elizabeth's family have called for the promotion of a greater understanding about domestic abuse and talked about the importance of working with children and young people in schools to facilitate community change.

109. The Birmingham Community Safety Partnership and its constituent agencies have provided evidence of their efforts, in recent years, to raise public and professional awareness of domestic abuse. They have demonstrated annual and seasonal campaigns variously targeting victims, perpetrators, family and friends and children. They have also demonstrated a range of methods used to get messages across including social media; local radio; television advertisements in health settings; running stalls in supermarkets; leaflets and posters displayed in community venues

[7] Further details on the Employer's Initiative on Domestic Abuse can be found at https://www.eida.org.uk/about-us

such as the hospital in which Elizabeth worked. The Partnership also provided evidence of commissioning work with children and young people around healthy relationships. This is in line with the national Ending Violence Against Women and Girls Strategy 2016-2020, but by no means universally applied across Birmingham's schools.

110. The level of activity demonstrated has been significant at times and the creativity and commitment of the many agencies and individuals involved is noteworthy. However, the activity of raising public awareness on domestic abuse and coercive control in Birmingham appears neither systematic nor universal in its coverage. This raises the question of what is the evidence base guiding the nature of effective awareness raising and prevention that local areas should undertake? It also raises the question about how much awareness raising and prevention is enough for a local area to be doing to satisfy its various duties in respect of violence prevention?

111. Early prevention of domestic violence can be seen to fall within the following categories:
- Primary prevention refers to the prevention of domestic violence before it happens
- Secondary prevention refers to the actions taken to minimise the risks and to prevent further harm when domestic violence is first known.

112. West Midlands Violence Prevention Alliance, a regional partnership of Police and Public Health, were consulted as part of this review to provide an expert view of the evidence around prevention. Whilst a growing body of evidence surrounds secondary prevention, the National Institute for Health and Care Excellence (NICE) have not yet demonstrated a robust evidence base around the best or sufficient method for primary prevention of domestic abuse (NICE, 2014). Hester and Lilley point out that the, "…absence of evidence should not be seen as evidence of absence" (2014; p.13) and the World Health Organisation (2009a) (2009b) and the 'Istanbul Convention'[8] each provide blueprints for preventive interventions in domestic abuse based on emerging evidence (2014; p.41).

113. Both the Government (2016) and Birmingham City Council (2018) have promoted the importance of prevention of domestic abuse in their most recent strategies to combat violence against women and girls and domestic abuse, respectively, each promoting well-regarded methods. For example, the national Strategy to End Violence Against Women and Girls states that "…educating and challenging young people about healthy relationships, abuse and consent is critical." (HM Government, 2016, p.16). This has been accompanied by a far-reaching campaign, "This is Abuse", aimed at encouraging teenagers to rethink their views of acceptable violence, abuse or controlling behaviour in relationships through a series of short films that were available online, in cinemas and on national television (HM Government, 2010 onwards).

[8] The 'Istanbul Convention' is commonly used to refer to the Council of Europe Convention on preventing and combating violence against women and domestic violence

114. Birmingham City Council's strategic ambition that "Birmingham is a place where domestic abuse is not tolerated; where everyone can expect equality and respect in their relationships, and live free from domestic abuse" (2018, p.11) is most certainly laudable. The range of actions listed in its new strategy, is most certainly diverse and extensive. However, for these actions to be meaningful, there needs to be a judgement made about how much is enough. For example, the strategy refers to undertaking community engagement and community-led preventative approaches. It needs to state how much of this activity is enough and how much public awareness is enough to challenge attitudes and prevent violence against women.

Recommendation 3: Public Awareness
Birmingham Community Safety Partnership defines the extent of the activities needed in the City to effectively change attitudes to violence against women and girls and the extent to which the Partnership is able to deliver them.

7. CONCLUSION

115. Elizabeth had been subject to coercive control from her husband and whilst she resisted this control, she was brutally killed by him when she tried to end their relationship.

116. Although the young couple had little contact with agencies, and none of the agencies concerned knew about the perpetrator's abuse, this review has been able to demonstrate the insidious nature of coercive control and how difficult it is for individuals, families, friends and professionals to define controlling behaviour as abusive.

117. The review has generated reflection on how to create opportunities in couple's therapeutic work for safely and directly asking about domestic abuse. It has also seen the significance of the workplace as a source of help for victims.

118. Perhaps most significantly, the review has considered the enormous task of changing societal attitudes to domestic abuse so that domestic abuse and violence against women is not only understood but is prevented before it begins. This domestic homicide review raises a challenge to Birmingham to determine how far their resources and capabilities allow them to undertake the preventative work that is needed and requires them to be transparent in the strategic prioritisation of work that will undertake.

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10. ACTION PLAN