



**Report of the Domestic Homicide Review Panel into the death of
Susan**

Commissioned by the Epping Forest Community Safety Partnership

Panel Chair Elizabeth Hanlon

Report Author John Gilbert

MAIN REPORT

April 2018

Definition of Domestic Violence

In March 2013, the government introduced a cross-government definition of domestic violence and abuse, which was designed to ensure a common approach to tackling domestic violence and abuse by different agencies. This definition states that domestic violence is:

“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: 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.”

This definition, which is not a legal definition, includes so called honour-based violence, female genital mutilation and forced marriage.

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1. The Review Process

Throughout the Review Report the following names are used to maintain the confidentiality of those persons referred to within the report. The terms mother, father, child, children, brother, sister, aunt and uncle are used where confidentiality is not compromised:

Perpetrator: Peter
Victim: Susan

Purpose

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

- (a) establish what lessons are to be learned from 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 upon, 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.

1.2 This review arises from a death within the area of the Epping Forest District Community Safety Partnership. The victim, a female aged 35 years, died in early 2016 as a result of an assault by her husband. The circumstances of the death therefore fulfil the criteria of section 9(3)(a) of the Domestic Violence, Crime and Victims Act 2004 in that the violence appeared to be perpetrated by a person with whom the victim had an intimate personal relationship

1.3 This DHR has been conducted in accordance with statutory guidance under section 9 of the Domestic Violence, Crime and Victims Act 2004. The review examines agency responses and any support provided to the victim prior to her death. The review considers agencies' involvement and contact with the victim and perpetrator for the period 1 May 2015 until the victim's death in February 2016.

1.4 Having considered all the evidence available to it, the Panel is of the view that there were no obvious ethnicity, culture, faith, sexual orientation, disability, gender or other diversity issues that had a bearing on the death of the victim or any agency involvement with the victim or perpetrator.

- 1.5 The Review Panel members would take this opportunity to extend the Panel's condolences to the family and friends of Susan and to all others who have been affected by her tragic death.

Panel Membership

- 1.6 The membership of the Review Panel was as follows:

Name	Position / Representing
Panel	
Elizabeth Hanlon	Chair
The late Councillor Gary Waller	Former Chair, Epping Forest District Community Safety Partnership
Alan Hall	Director of Communities, Epping Forest District Council
Caroline Wiggins	Community Safety Manager, Epping Forest District Council
Ruth Rose	Senior Legal Officer, Epping Forest District Council
Joanne Majauskis	Programme & Practice Manager, Safer Places
Mohammed Shofiuzzaman	Adult Safeguarding Manager, West Essex Clinical Commissioning Group
Ian Cummings	DCI, Essex Police
Val Billings	Essex Domestic Abuse Officer, Essex Safeguarding Adults Board
Non Panel	
John Gilbert	Review Report Author
Julie Chandler	Assistant Director (Community Services and Safety), Epping Forest District Council
Colin Rowell	Voluntary Action Epping Forest (Administration)

In addition, at the invitation of the Panel Chair, the Essex Police Senior Investigating Officer, DI Stephen Jennings, attended a number of meetings to advise the Panel following the conclusion of the investigation and criminal proceedings.

Timetable

- 1.7 The Review commenced on 2 March 2016 when the late Councillor Gary Waller, the former Chair of the Epping Forest District Community Safety Partnership, notified the Home Office of the intention to establish a Domestic Homicide Review Panel. The initial meeting of the Review Panel took place on 3 May 2016. At this meeting a communications strategy was produced in relation to the DHR. This will be amended prior to any publication.
- 1.8 In view of the ongoing criminal proceedings, and the request of the Senior Investigating Officer from Essex Police that no contact be made with family and friends of the victim and perpetrator during the criminal investigation, the Review Panel decided that whilst a scoping exercise of relevant agencies should be commenced, the Review Panel would not meet substantively again until such time as

the criminal proceedings had concluded. In view of lengthy delays in bringing the matter to court, it became evident that the Home Office requirement for the final report to be submitted within six months of the death could not be met, and therefore the Review Panel agreed to seek an extension of time from the Epping Forest District Community Safety Partnership (CSP). The CSP was requested to agree a time delay of either:

- (a) six months from the date of a guilty plea in July 2016 by the perpetrator; or
- (b) six months from the date of the court hearing in November 2016 in the event of a not guilty plea.

1.9 The CSP agreed to this request. The perpetrator, Peter pleaded not guilty to murder and therefore the completion deadline for the Review Report was extended until 31 July 2017, and the Home Office was duly informed of this extension by the Chair of the CSP.

Confidentiality

1.10 All information received by this Review Panel has been treated in the strictest confidence. All Review Panel members were made aware of the strict requirement not to disclose or discuss any information provided to the Review Panel without the express consent of the Review Panel.

1.11 The findings and conclusions of this review remained confidential during the review process. Information was only available to Panel members until such time as the Panel Review Report was approved for publication by the Home Office Quality Assurance Group. The Home Office Quality Assurance Group letter of approval is attached as Appendix C and any suggested amendments referred to in that letter have been considered and incorporated within this final Review Report where considered appropriate.

Epping Forest District Community Safety Partnership (CSP)

1.12 In February 2016 the death of Susan was reported to the late Councillor Gary Waller, the former Chair of the CSP, by Essex Police, stating that the death had occurred within the administrative district of the CSP. Following discussions with Essex Police and the Essex Domestic Violence Co-ordinator, Councillor Waller concluded that the death should be treated as a domestic homicide and on 2 March 2016 the Home Office was informed that a Domestic Homicide Review Panel would be established.

Review Panel Chair

1.13 Mrs Elizabeth Hanlon is a former Detective Chief Inspector with the Hertfordshire Constabulary. In that role she had been a member of an earlier Domestic Homicide Review Panel within the administrative district of the CSP and had also been involved with a number of Domestic Homicide Reviews elsewhere in the region. On leaving the Hertfordshire Constabulary, Mrs Hanlon was appointed as the Chair of the

Hertfordshire Safeguarding Adults Board, and given her all round experience of domestic abuse and related issues, Councillor Waller formed the view that she should be asked to chair this Review Panel. Mrs Hanlon has no direct links with the Epping Forest District Council or Epping Forest CSP. Mrs Hanlon was appointed to that role at the first meeting of this Review Panel on 3 May 2016.

Report Author

1.14 The Review Report was authored by Mr John Gilbert who is a former Director of Environment and Street Scene at Epping Forest District Council. In that role he was a Review Panel member and report author for a number of Domestic Homicide Reviews. Mr Gilbert retired from Epping Forest District Council in May 2014 and no longer has links with either the Council or Epping Forest CSP. Mr Gilbert was appointed to this role at the first meeting of the Review Panel on 3 May 2016.

The Coroner's Inquest

1.15 The Coroner for Essex was informed that the CSP had established a Domestic Homicide Review Panel to review the death of Susan. Given the outcome of the criminal investigation and the perpetrator being found guilty of murder, no inquest was held and the coroner therefore closed the case.

Scope of the Review

1.16 At the first Review Panel meeting on 3 May 2016, it was agreed that until further information was received, the draft Terms of Reference should reflect those of other reviews. It was further agreed to reconsider the draft Terms of Reference at the next Review Panel meeting. It was considered that despite there being no final Terms of Reference in place, this should not prevent the commencement of the scoping exercise whilst the criminal process was proceeding.

1.17 At the Review Panel meeting held on 6 January 2017 the draft Terms of Reference were considered and amendments suggested. The final Terms of Reference were considered by the Review Panel at its meeting on 31 March 2017 and agreed as follows:

- (1) *In conducting the Domestic Homicide Review into the death of Susan, the Panel shall have regard to:*
 - (a) *The Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews¹ and the recommended Home Office security provisions²; and*
 - (b) *The Essex Domestic Abuse Strategy Group - Domestic Homicide Reviews Guidance³.*

¹ Home Office "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews" (December 2016)

² Full personal details to be provided to the Review Panel, but published documents will be redacted or anonymised

³ Safer Essex "Domestic Homicide Review Guidance" (May 2015)

- (2) *The Panel shall conduct the review on the basis that Susan was murdered in early 2016 by her husband Peter at the couple's home address.*
- (3) *The Panel will seek to establish the nature of the relationship between Susan and her husband Peter prior to her death, and the manner of her death will be confirmed.*
- (4) *The Panel will review the outcome of the scoping exercise in order to determine which agencies, organisations and individuals should be requested to submit an IMR⁴. Based upon that review, the Panel will issue a request for IMRs and upon their return consider their content to determine the extent of their knowledge of Susan and Peter prior to her death, and any actions taken or offered in relation to them. IMRs will be required to cover the time spanning at least between the 1st of May 2015 (i.e. around the time that Peter commenced an affair with another female) and the date of her death and if agencies, organisations or individuals consider that events outside of this time frame are significant and of relevance to the review, then they should include that information setting out the dates involved.*
- (5) *In the light of information arising from (4) above, the Panel shall consider whether such practitioners or agencies:*
 - (a) *need to increase their own levels of awareness and information gathering;*
 - (b) *were appreciative of and sensitive to the needs of Susan; and*
 - (c) *were knowledgeable about potential indicators of domestic abuse and aware of actions they could take if such concerns had arisen.*
- (6) *The Panel shall consider the role of any practitioners or agencies that had not come into contact with Susan and/or Peter that might reasonably have been expected to do so.*
- (7) *The Panel shall seek to co-ordinate its work with that of HM Coroner for Essex and any inquest that is underway. The Panel shall remain cognisant of the outcome of the trial of Peter and any subsequent legal process that may follow his conviction for the murder of Susan. The Panel shall also seek relevant information from the Crown Prosecution Service, the police and Peter's defence counsel in relation to the court case.*
- (8) *The Panel shall consider which members of Susan's and Peter's family or friends should be asked to contribute to information gathering, and how that would then be managed. The Panel will particularly seek to establish whether:*
 - (a) *Susan had made any disclosures to family or friends in respect of the state of her marital relationship with Peter;*

⁴ IMR – "Individual Management Review"

- (b) *Peter had exhibited any tendency towards domestic violence towards Susan;*
 - (c) *Peter had made any disclosures to family or friends in respect of the state of his marital relationship with Susan; and*
 - (d) *Peter had expressed any intention to bring the relationship to an end or to harm Susan.*
- (9) *The Panel shall seek information in respect of the background and any previous convictions of Peter and whether or not he had ever been subject to Multi- Agency Public Protection (MAPPA) Arrangements or Domestic Violence Perpetrator Programmes (DVPP).*
- (10) *The Overview Report shall be written by the nominated Review Panel Report Author who shall, subject to the agreement of the Panel Chair, submit a draft to the Panel for its consideration. The Report shall set out the extent to which the homicide could have been anticipated and possibly prevented, and whether, from the findings of the review, there are improvements that could be made in the way in which relevant agencies and organisations can work individually or together to safeguard future potential victims. The Panel shall also consider whether further information should be made available in the public domain for the benefit of family or friends who have concerns relating to potential abusive relationships.*
- (11) *Subject to (10) above, the Panel will identify any changes in policies and procedures arising from the lessons learnt, make recommendations and will, through an agreed Action Plan, establish timescales for their implementation and identify what is likely to change as a result.*
- (12) *The Panel shall, once it has agreed the final report, submit it to the Epping Forest District Community Safety Partnership for its consideration. The Partnership will be requested to consider the content of the report, the recommendations and the associated Action Plan. If the Partnership is satisfied with the report, it shall be requested to:*
- (a) *submit the report to the Home Office;*
 - (b) *consider whether, prior to the Home Office response, there are issues that should be brought to the immediate attention of Safer Essex; and*
 - (c) *consider which agencies, organisations or individuals should receive a copy of the report and the degree to which its findings should be made public, following the approval of the report by the Home Office.*
- (13) *The Panel shall seek to complete its work before the 31st of July 2017, that being the date before which the Epping Forest District Community Safety Partnership should submit the final report to the Home Office. Should the Panel consider that this date cannot be achieved it shall take immediate steps to seek the consent of the Epping Forest District Community Safety Partnership to seek an extension of time.*

Review Methodology

- 1.18 This Domestic Homicide Review (DHR) has followed the statutory guidance issued by the Home Office¹ for the conduct of such reviews. The Review Panel undertook a scoping exercise in order to gather information about the victim Susan and the perpetrator Peter. In accordance with the agreed Terms of Reference, the scoping exercise sought information covering the period from 1 May 2015 until the date of her death in early 2016. The selection of the start of May reflects this being the time when it is believed that Peter commenced an affair with another female, and when Susan identified difficulties in their marriage and started to challenge Peter around those difficulties. A total of 51 agencies, organisations and individuals were approached, of which 6 responded with information. The Review Panel considered all of the responses to the scoping exercise, but, in view of the relative lack of relevant information on the victim and the perpetrator, it was decided that formal IMRs were not required and were therefore not sought. The information from the agencies was presented to the Review Panel by representatives of those agencies and the Panel members had an opportunity to seek additional information through questioning.
- 1.19 More detailed information was sought, and by the conclusion of the Review information had been received from:
- (a) The General Practitioners to Susan and Peter;
 - (b) Princess Alexandra Hospital (Harlow) regarding Peter;
 - (c) The Head Teacher of the school attended by the children of Susan and Peter;
 - (d) The Crown Prosecution Service;
 - (e) The East of England Ambulance Service; and
 - (f) The Essex Fire and Rescue Service.
- 1.20 At the outset of the Panel inquiry process, Susan's parents were contacted to inform them that a DHR Review had been established and that once the criminal proceedings had been concluded, they would be invited to contribute to the review process.
- 1.21 Once the criminal proceedings against Peter had concluded, the Review Panel sought to gather information from the family and friends of Susan. Throughout the period of the review numerous attempts were made to engage with Susan's family including writing to them and making requests for engagement via the police Family Liaison Officer. Unfortunately, at that time, all these attempts did not result in Susan's family directly engaging with the Panel. Similar attempts were made to engage with Susan's friends, but with the same negative outcome. The Panel also considered approaching Susan's work colleagues to obtain background information, but since she had only been in that particular employment for a very short period (three weeks), it was considered unlikely that any useful information would be obtained. It was later established through information received from Susan's family that Susan had gone to work with a family friend in their pub.

- 1.22 Some information was made available to the Panel Chair by Essex Police, who released statements provided to them by Susan's family and friends as part of the criminal case against Peter. That information provided the Review Panel with helpful insights into the relationship between Susan and Peter. Although, at this time, Susan's parents declined to engage directly with the Panel, Susan's mother took part in a radio interview soon after the completion of the criminal process and Peter's conviction for murder. This interview was recorded for the benefit of the Panel and provided some useful insight into her views and Susan's personal circumstances within her marriage.
- 1.23 Susan had attended her general practitioner's surgery on numerous occasions in the period covered by the Terms of Reference. The surgery provided full details of attendances after 13 February 2013 to the Review Panel that were reviewed by the Clinical Commissioning Group's representative on the Review Panel.
- 1.24 There was no information available from Peter's GP, but there was information provided by the Princess Alexandra Hospital, Harlow, following his involvement in a road traffic accident in early 2014.
- 1.25 The Panel attempted to obtain information from the female with whom Peter was in a relationship outside the marriage. Despite making approaches via the Police Family Liaison Officer, the female chose not to engage.
- 1.26 Attempts were also made to seek information from Peter's parents and his former employers. Neither were prepared to engage with the Panel. Consideration was given to meeting Peter whilst he was in prison, but the advice from the Police was that this was unlikely to be of assistance due to Peter's inability to accept that he had committed a crime and because there remained a possibility of an appeal against conviction and sentence. However, a letter was written to Peter, in prison, to notify him that a Domestic Homicide Review was taking place.
- 1.27 At the conclusion of the review process, the Panel Chair wrote once more to Susan's parents asking for their comments and seeking a meeting to determine whether they could provide further insight into their daughter's relationship with Peter. Family members of Susan felt that they were unable to speak about the death of Susan at that time however contact has since been made with Susan's family who very kindly agreed to talk about Susan and Peter and their relationship. The family met with the CSP Community Safety lead and the chair of the panel Elizabeth Hanlon. We would like to acknowledge how difficult this must have been for the family and we would like to thank them for their time.
- 1.28 The Panel also gave consideration as to the benefits of attempting to speak to Peter, in prison. However, given Susan's mother's views on Peter's inability to accept that he was in any way at fault for the tensions within their marriage, coupled with his failure to demonstrate any remorse for his actions during his trial, it was concluded that it would be inappropriate to arrange such a visit.

2. The Facts

- 2.1 On a day in early 2016 at around 15:30 the ambulance service received a call from Peter stating that he had just found his wife Susan collapsed at home, along with signs of a fire. He gave his home address and was given advice on how to administer Cardiac Pulmonary Resuscitation (CPR).
- 2.2 The first paramedic to arrive at the scene described finding a female lying on the floor in the kitchen, burnt. At 15:40 the paramedic recognised that the female was deceased and that the body was not warm to the touch, suggesting that death had occurred sometime earlier.
- 2.3 The police were called to the scene by the ambulance service at 15:45. On arrival at the scene the police officers were informed by the paramedic that a deceased female was inside the house with severe burns. The paramedic could not explain how the burns could have arisen. The duty police inspector formed the view that the death was “unexplained” and that a full investigation and post-mortem examination would be required. A Detective Chief Inspector (DCI) was informed of the circumstances and attended the scene. The DCI agreed that the circumstances of the death appeared suspicious and a crime scene was established.
- 2.4 The post-mortem examination indicated that there was no evidence of natural causes for the death, but there was extensive burning to Susan’s head and trunk and bruising to the right side of her face and left side of her head, consistent with some form of assault and subsequent fire. Furthermore, traces of white spirit were found on Susan’s clothing suggesting that, following the assault, Susan’s body had been set on fire by the perpetrator. Contrary expert evidence was given in the subsequent murder trial as to the cause of death. However, the victim’s death certificate states ‘death by immolation with an accelerant.
- 2.5 On the basis of the evidence, Peter was charged with the murder of Susan, and he was subsequently found guilty of murder and arson, resulting in a life sentence with a minimum period of 24 years before parole.

Susan

- 2.6 Susan was born in December 1980. At the time of her death she was 35 years of age and living in a semi-detached house within the Epping Forest District. She had been married to Peter for 8 years and they had two children, aged 6 and 4. She was an only child. Her parents described her as someone who “lived for her family... and her two darling children”. She had no previous police or related agency involvement or record.
- 2.7 Friends and family described Susan as a worrier who could often become anxious. However, no friend or relative ever considered Susan to be at risk in her personal life. Family members have since reflected on the relationship Susan had with Peter and

believe that he was controlling Susan throughout their relationship and that Peter was not happy unless he had Susan's full attention and that she was doing what he believed was his priorities. They reflected that these observations are in hindsight and at the time of their relationship they believed that Peter was 'selfish' and 'spoilt' but that they did not have any concerns in relation to Susan's wellbeing. Susan had kept written notes of her relationship with Peter which indicated her concerns about his potential adultery. However, she felt that she should do nothing that might bring the relationship to an end, despite the fact that the stresses in their relationship were, in her opinion, of his making, not hers.

- 2.8 In statements made to the police during their criminal investigation, her friends variously described her as a "wonderful mother and wife", who was very organised around the home. They said that when with her friends she was relaxed and open, but was always considerably more reserved when her husband Peter was present. However, no friend indicated that Susan had expressed any concerns regarding her safety or had suggested that she was being subjected to any form of domestic abuse.
- 2.9 Susan's family described Susan as being loving, loyal, kind and beautiful, both inside and out. She was extremely conscientious in everything that she undertook.
- 2.10 The family stated that Susan met Peter at work and that she was swept off of her feet. Peter was described as being charming and very confident and that he did everything possible to please Susan, showering her with gifts and attention, going to great lengths to please her. It was described as a whirl wind romance and that they quickly moved in together and soon afterwards got married. After the birth of their first child they decided that they would move to live nearer Peters parents but later changed their mind and brought their house. They had their second child within 21 months.
- 2.11 The family described the relationship between Susan and Peter as changing shortly after the children were born. Peter appeared to be jealous of all the attention that Susan was giving the children and stated that he wasn't being given enough attention. They believe that Peter started blaming Susan for everything that went wrong including why he lost his job. He had tried to get Susan to put some pressure on her friends and family to get Peter another job and when this didn't happen Susan was blamed for not trying hard enough
- 2.12 Six weeks before the murder, Susan told her family that Peter had threatened her that if she didn't improve and become more attentive towards him then he would seek a divorce and sell the family home.
- 2.13 During this period Susan found out that Peter had secretly consulted a divorce lawyer and that he had a file on his computer titled 'Susan' where he had listed all her misdemeanours. Susan was desperate to make the relationship work as she did not want her children to grow up in a divorced family.
- 2.14 In May 2015, Susan discovered flirtatious text messages on Peters phone. Susan had confronted Peter and the female regarding an affair but had been told that it was all

in her mind and that she was imagining things. Family describe the relationship as going downhill afterwards.

- 2.15 Her medical history was relatively unremarkable with the majority of attendances being related to contraception. In December 2015 she consulted her GP regarding 'difficulties at home', although there were no details in her record. In December 2015 she confided in her GP that her husband had admitted adultery and that as a result they were attending counselling as a couple. However, Susan felt that the counselling sessions were actually making matters between her and Peter worse rather than better. Following a similar conversation with her GP in January 2016 Susan was prescribed an anti-depressant for her anxiousness.
- 2.16 The family describe Peter as being controlling and that he would try and get Susan to do things his way. They described instances when Peter would come home deliberately late if he knew that Susan was going out and that he would deliberately make things difficult for her.
- 2.17 Family members were not aware of any incidents of violence towards Susan, however they did quote an occasion where Peter deliberately made Susan fear for her life i.e. driving up the motorway 100 MPH eating and drinking. Family felt that Peter used instances like this as a controlling mechanism.

Peter

- 2.18 Peter was born in June 1976. At the time of the murder of Susan he was 39 years of age and living with Susan in the same house. He was the father of their two children, aged 6 and 4. He had no previous police or related agency involvement or record.
- 2.19 There is no direct information available on Peter's family and background other than that provided by the friends and family of Susan. He worked in the finance industry and although made redundant on a number of occasions, he had always been able to find new employment. He had again been made redundant just prior to the death of Susan, but there appeared to be no immediate financial consequences associated with this, demonstrated by the booking of holidays and the purchase of a caravan located in Suffolk.
- 2.20 It has been established that Peter had been in a relationship with another female in the period immediately before Susan's death. Susan had become aware of that and had confronted Peter about it. Information provided by friends and family suggests that Peter was sufficiently unhappy with his marriage to Susan that he was contemplating bringing the relationship to an end.
- 2.21 The night before the death of Susan, she and Peter had enjoyed a meal and spent the night together as a normal married couple. However, on the day of her death they had apparently argued with one another due to Susan finding messages on Peter's mobile phone between him and the female who he was seeing outside of their

marriage. Peter had also arranged to meet with the same female on the day of Susan's death.

- 2.22 A number of the statements provided by friends of Susan to the police as part of their criminal investigation, refer to Peter as being somewhat self-centred and always finding fault with the actions or inactions of Susan. He had made a number of comments regarding Susan's mental state, on one occasion telling her parents that they 'should sort her out ...'. Interestingly this attitude from Peter was maintained during his eventual trial, when he appeared to demonstrate no remorse for the death of Susan or for the effects that the death of their mother and his own likely imprisonment would have upon his two young children.
- 2.23 Furthermore, it appeared that Peter was someone who liked to maintain his lifestyle irrespective of the cost of maintaining that lifestyle.

Legal Process

- 2.24 Following the conclusion of the criminal investigation, Peter appeared at Crown Court in late 2016, where he pleaded not guilty to the murder of Susan and not guilty to arson. Following the trial by jury, Peter was found guilty of both charges and was sentenced to life imprisonment for the murder of Susan and six and a half years for arson, the sentences to run concurrently. The Presiding Judge imposed a minimum term of 24 years imprisonment before consideration for parole.
- 2.25 In his sentencing remarks the Presiding Judge made particular reference to the savagery of the attack and the fact that Peter had lied throughout the entire criminal investigation and subsequent court case.
- 2.26 Given the outcome of the criminal proceedings, the Coroner for Essex concluded that no inquest was necessary, and the case was therefore closed.

3. Key Issues and Analysis

- 3.1 Given the circumstances of this domestic homicide it is difficult to adduce any particular issue or factor as key in leading up to the death of Susan in early 2016, although there are some factors which may have resulted in Peter making the decision to kill Susan:
- (a) his latest redundancy;
 - (b) financial pressures and effects upon his lifestyle arising from that redundancy;
 - (c) and his relationship with a female resulting in a potential divorce from Susan.
- 3.2 Despite the factors referenced above suggesting that Susan's and Peter's marriage was in a degree of difficulty in the period leading up to her death, there was no clear evidence that anyone who knew Susan considered that she was in any way at risk of harm at the hands of Peter. Whilst there was evidence to suggest that Peter may have been intending to leave his wife, presumably in favour of the female with whom

he was having a relationship, there was again no specific evidence or information available that indicated he intended in any way to harm Susan.

- 3.3 The only agencies that had any contact with Susan or Peter had been their general practitioners or Princess Alexandra Hospital Accident and Emergency Department. Whilst Susan had confided in her GP that her marriage was in difficulty and that she was suffering from anxiety, there is again no information to suggest that Susan had indicated any concerns that she had been subjected to any form of domestic abuse or that she considered herself or her children to be at risk due to the behaviour of Peter. The head teacher at the school attended by the couple's children stated that she was unaware of any marital disharmony and that the children were behaving normally for children of their age.
- 3.4 This situation is further borne out through the statements to the police of friends and family, many of whom made reference to the difficulties in the marriage, Peter's somewhat uncaring attitude towards Susan and his relationship with another female, but in no instance suggested that they were in any way concerned for the welfare of Susan or her children. Furthermore, given how close Susan was to her mother, seeing her almost on a daily basis, it is very likely that she would have confided in her mother if she felt that she was being subjected to any form of domestic violence (i.e. physical and/or non-physical) or was in any way concerned for her safety and/or the safety of her children. The only times that Susan's parents mentioned any concern about Peter was in the immediate aftermath of her death, when they asked the police whether Peter had been responsible for the death of their daughter, and during a radio interview following Peter's conviction for murder when Susan's mother stated that "he was controlling her, bullying her...".
- 3.5 Whilst Susan herself was clearly anxious about the activities of her husband, she was making attempts to maintain their marriage, through for example, counselling. Although she felt that the counselling was not improving matters and that ultimately she might be held responsible for the end of her marriage, she again, in her written diary notes provided as part of evidence in the criminal prosecution, expressed no concerns that she was suffering from or might be at risk of physical or other harm from Peter. Furthermore, there was also nothing to suggest that there had been any bar to Susan reporting any such concerns, should she have harboured them, to any agency or organisation. Indeed, her closest friends in their statements to the police said quite clearly how open she was with them in sharing information, and in her consultations with her GP, no such concerns were directly raised.
- 3.6 However, with the benefit of hindsight and the widening of the definition of Domestic Abuse to specifically include emotional, psychological and coercive abuse, the Panel is of the view that Peter's behaviour towards Susan could possibly have been construed as falling within this revised definition. The Panel does however recognise the subtleties of coercive and controlling behaviour, and that Susan, and indeed her family and friends, probably did not recognise Peter's actions as constituting Domestic Abuse. The family now describe their daughter as a victim of 'Gaslighting' by Peter. Gaslighting is an extremely effective form of emotional

abuse that causes a victim to question their own feelings, instincts and sanity, which gives the abusive partner a lot of power. Once an abusive partner has broken down the victim's ability to trust their own perceptions, the victim is more likely to stay in the abusive relationship.

- 3.7 Peter was described as being the dominant person in the relationship and that over time this had an impact on Susan. Family described Susan as starting to doubt her own appearance and self-worth, questioning if all the things that went wrong was her fault. Peter started informing Susan that if 'she' was different then everything would go back to being good again and they would go back to having a 'perfect world'.
- 3.8. Even taking into account the revised definition, from the evidence seen by the Panel it would be very difficult to positively conclude that there had been events prior to the murder that should have been seen as warning signs by any agency, professional, member of family or friend. Furthermore, the Review Panel found that no agency or organisation was in possession of any information that should have been shared in order to determine and manage any potential risks to Susan.
- 3.9 The Review Panel considered whether there were any learning opportunities arising from this tragic incident and has concluded that in this case no individual, agency or organisation could reasonably have foreseen or been aware of the intentions of Peter towards his wife Susan. The panel did conclude, however, that agencies were not aware of the significance of the impact of coercion and control on Susan.
- 3.10 Although within West Essex the IRIS⁵ project has not been commissioned, the Panel learnt that there was an extensive programme of training in place regarding the recognition of, and support for, adults experiencing domestic abuse and that this training had been provided to a wide range of health professionals including GPs, nurses, social workers, police officers and safeguarding leads in schools. This training involves the full definition of domestic abuse including coercive, controlling and threatening behaviour. The Panel noted that this training has continued in subsequent years, with the introduction of the J9 initiative⁶. Alongside J9, other initiatives have also been implemented, including for example:
- (a) the presence of Independent Domestic Violence Advisors at local A&E Departments; and
 - (b) information regarding domestic abuse available in locations such as inter alia, Jobcentres, Council Offices, Community centres, GP Surgeries and Children's Centres.

⁵ "IRIS" – "Identification and Referral to Improve Safety" – a General Practice based domestic violence and abuse training support and referral programme. (Trialled in Hackney & Bristol in the period 2007 to 2010 – ref: irisdomeesticviolence.org.uk).

⁶ "J9" – an initiative intended to increase awareness of DVA and provide support to those who may victims of DVA. Training is available across the County of Essex provided by Safer Places and is in full operation within a number of Essex District Councils including Epping Forest.

3.11 Whilst the Panel recognises the huge strides made in identifying and making available services to those who are subject to domestic abuse, the Panel believes that health professionals should remain mindful at all times, that symptoms of depression or similar may well be masking an underlying episode or episodes of domestic abuse, whether or not there are accompanying physical signs of such abuse. Therefore, health professionals should ensure that they remain familiar with relevant local services and initiatives designed to support those being subject to potential domestic abuse, such as J9⁶ and make referrals accordingly.

4. Conclusions and Recommendations

4.1 The Review Panel has been careful to ensure that hindsight has not resulted in the criticism of any agency or organisation

4.2 The Review Panel has, after careful consideration of the information available to it, formed the view that the death of Susan could not reasonably have been foreseen nor prevented by any agency, organisation or individual. Furthermore, the Panel is of the view that irrespective of the existence within West Essex of services and initiatives such as J9⁶, it is likely that Susan, her family or friends would not have recognised that she might be a victim of domestic abuse and therefore might not have benefitted from accessing them.

4.3 Despite the conclusions drawn, the Panel proposes to put forward two recommendations relating to health professionals and wider dissemination of information. In so doing the Panel recognises the pressures which exist within the relevant community-based services and the fact that despite the availability of various support services and initiatives, such as IRIS⁵ and J9⁶, many persons suffering from domestic abuse, especially if non-physical in nature, do not recognise themselves as being subject to domestic abuse.

4.4 The Review Panel therefore recommends as follows:

(1) That, given the widening of the scope of the definition of domestic abuse to include emotional, psychological and coercive abuse (i.e. non-physical abuse), the West Essex Clinical Commissioning Group (CCG) should remind all relevant health professionals who are often in the privileged position of speaking to individuals in the absence of their partners and hearing their concerns, of these changes, so that they may recognise potential domestic violence through non-physical symptoms (e.g. depression, low self-esteem, lack of self-confidence etc.) and make referrals to relevant services and initiatives; and

(2) That all public facing agencies should make available to their staff and local teams leaflets, posters and other advisory information relating to the wider definition of domestic abuse and the outreach services that are available to those who believe that they may be subject to domestic abuse.

Family members described Susan as being a loving mother and that she lived her life for them.

“Her beautiful children remain her enduring legacy. We hope to raise them to become fine adults contributing to society, hoping that they will be scarred but not damaged by the tragic loss of their mother”

Appendix A – Participation in the Review

1. The following agencies, organisations and persons were either sent full scoping documents or requests for information/meetings:

Alcohol and Drug Advisory Service
Anglian Community Enterprise
Anglian Community Enterprise
Basildon & Brentwood CCG
Basildon District Council
Basildon Women’s Aid
Braintree District Council
Brentwood District Council
Basildon and Thurrock University Hospitals
Castle Point & Rochford Clinical Commissioning Group
Castle Point District Council
Chelmsford City Council
Colchester Borough Council
Colchester Hospital University Foundation Trust
Coopersale Hall School
Crown Prosecution Service
Criminal Justice Substance Misuse Service
East of England Ambulance Service
Epping Forest District Council
Essex County Council Head of Adult Safeguarding
Essex County Fire and Rescue Service
Essex Community Rehabilitation Company
Essex Head of Children’s Safeguarding
Essex Police
Essex Probation Service
Harlow Council
High Street Epping Practice
HM Prison Service
Maldon District Council
Mid Essex Clinical Commissioning Group
Mid Essex Hospital Trust
North East Essex Clinical Commissioning Group
North Essex Partnership Foundation Trust
NHS England - GP Services Primary Care
North Essex Partnership Trust

Open Road
Princess Alexandra Hospital Harlow
Provide
Public Health Essex
Rochford Safer Places
South Essex Partnership Trust
South Essex Rape and Incest Crisis Centre
Southend Clinical Commissioning Group
Southend District Council
Southend University Hospital Trust
Specialist Treatment & Recovery Service
Tendring District Council
The Limes GP Medical Centre, Epping
Thurrock Adult Social Care
Thurrock Clinical Commissioning Group
Thurrock Council
Uttlesford District Council
West Essex Clinical Commissioning Group

2. The following agencies, organisations and persons provided information to the Review Panel:

The General Practitioners to Susan and Peter;
Princess Alexandra Hospital (Harlow) regarding Peter;
The Head Teacher of the school attended by the children of Susan and Peter;
The Crown Prosecution Service;
The East of England Ambulance Service; and
The Essex Fire and Rescue Service

Appendix B – Action Plan

Ref	Recommendation	Local/Regional/ National	Action	Lead Agency	Milestones	Target date	Completion date
4.4.1	That, given the widening of the scope of the definition of Domestic Abuse to include emotional, psychological and coercive abuse (i.e. non-physical abuse), the West Essex CCG should remind all relevant health professionals who are often in the privileged position of speaking to individuals in the absence of their partners and hearing their concerns, of these changes, through appropriate guidance or training so that they may recognise potential domestic violence through non-physical symptoms (e.g. depression, low self-esteem, lack of self-confidence etc.) and make referrals to relevant outreach services	Local	Guidance/training be offered/issued to GP practices and other related health professionals	West Essex CCG			
4.4.2	That all public facing agencies should make available to their staff and local teams leaflets, posters and other advisory information relating to the wider definition of domestic abuse and the outreach services that are available to those who believe that they may be subject to domestic abuse	Local	Relevant information issued to public facing agencies	Epping Forest CSP			

Appendix C – Home Office Quality Assurance Group Letter



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