SETDAB | Southend, Essex & Thurrock Domestic Abuse Board

Domestic Homicide Review
Overview Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Colchester Community Safety Partnership

A Review into the death of Beth in January 2021

Report produced by Joanne Majauskis

Date 10th June 2022

SAFER COLCHESTER PARTNERSHIP

Preface

This is a Domestic Homicide Review Report referring to the life and death of “Beth”. This is a pseudonym and will be used throughout this report.

I would like to begin by expressing my sincere sympathies, and that of the panel, to the family and friends of “Beth”.

The review was commissioned by the Colchester Community Safety Partnership on receiving notification of the death of Beth in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004. It follows the guidance set out by the Home Office.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address the issues that it has raised. I would like to thank all those who contributed.

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Section One - Introduction

1. Introduction

1.1 This Domestic Homicide Review report examines the circumstances surrounding the death of Beth, a 21-year-old US citizen who had been staying in the UK on a 6-month visa to visit her boyfriend, Zach. She was killed by Zach, in January 2021 in the multi-occupancy student accommodation in which they had been living.

1.2 The primary purpose of a Domestic Homicide Review (DHR) is to enable learning. In order for the learning to be shared as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly what needs to change in order to reduce the risk of such tragedies happening again in the future.

2. Summary of circumstances leading to the review

2.1 This Domestic Homicide Review (DHR) has been conducted in accordance with statutory guidance under section 9(1) of the Domestic Violence, Crime and Victims Act 2004.

2.2 This report was commissioned by Colchester Community Safety Partnership (SCSP) under the centralised process agreed by the Southend, Essex and Thurrock Domestic Abuse Board (SETDAB).

2.3 The circumstances of the death of the victim fulfil the criteria of Section 9 (3)(b) of the Domestic Violence, Crime and Victims Act 2004 in that the homicide was carried out by a person to whom she was or had been in an intimate personal relationship with.

2.4 Beth was found deceased in January 2021 by police following a 999 call from Zach's father. Zach had called his father and told him he had stabbed someone and, they were dead on the floor. Zach was charged with her murder, he denies this but has admitted manslaughter by reason of diminished responsibility.

3. Confidentiality

3.1 The findings of this review are confidential. Information is available only to participating professionals and their line managers until the review has been approved by the Home Office. Following approval, the report should be shared appropriately within and between organisations in order to disseminate the learning.

3.2 Before the report is published the Southend, Essex and Thurrock Domestic Abuse Board (SETDAB) Domestic Abuse Team and Colchester Community Safety Partnership will circulate the final version to all members of the review panel and the family members. The family will be notified of the publication date.

3.3 To protect the identity of those involved the following pseudonyms have been used throughout this report:

Beth and Zach, both were 21 years old at the time of the murder.

4. Terms of Reference

Statutory Guidance (Section 2.7) states the purpose of the DHR Review is to:

4.1. Establish what lessons are to be learned regarding the way in which local professionals and organisations work individually and together to safeguard victims.

4.2. 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.

4.3. Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

4.4. 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.

4.5. Contribute to a better understanding of the nature of domestic violence and abuse.

4.6 Highlight good practice.

Specific Terms of Reference

4.7 This report of a domestic homicide review will consider relevant past agency contact and involvement with Beth and Zach. In particular will focus on the time from 5th October 2019 until the time of the incident as initial intelligence suggested that this was when their relationship commenced. Subsequent information suggests the relationship may have been longer; Zach attended an appointment with his private psychiatrist in Sept 19 with his "American girlfriend" and stated they had been together for two years. However, all significant incidents involving police and other agencies fall within the initial timeframe identified for review.

4.8 The independent chair agreed the Terms of Reference for the Review with the Southend Essex and Thurrock Domestic Homicide Review Team, the Safer Colchester Partnership and panel members. The key issues identified were:

- The level of information agencies held and understand regarding Zach's: Mental Health and Disability status
- Any concerns known around controlling and coercive behaviour in Beth and Zach's relationship
- Knowledge of any potential risks posed to others by Zach
- Safeguarding procedures when someone makes a disclosure of mental health issues
- Procedures when someone refuses to engage in a risk assessment
- Decision making processes regarding identification of victims and perpetrators in domestic abuse cases

4.9 Agencies completing IMRs were required to analyse these issues in relation to their contact with Beth or Zach, with specific reference to:

- What policies, procedures and guidelines provide the framework for the agency's response to the above issues.
- What training is available to, and accessed by, staff in relation to responding to the above issues.
- What communication should have taken place between agencies in relation to the above issues; whether this took place; the quality and outcomes of that communication.

5. Methodology

5.1 Essex Police notified SETDAB and Safer Colchester Partnership of the homicide on 27th January 2021.

5.2 The Domestic Homicide Review Core Group met to discuss the case on 25th February 2021. Following further enquiries and correspondence with the Home Office, a decision was reached that the homicide met the criteria for a Domestic Homicide Review (DHR) in May 2021.

5.3 A scoping exercise was carried out to identify relevant agencies who made have had contact with either Beth or Zach and agencies were ask that they secure their records. The Core Group agreed, based on the scoping information gathered, that a DHR would be commissioned.

5.4 An Independent Chair, Joanne Majauskis, was appointed to carry out the review in May 2021.

5.5 Where it was established that there had been contact, agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members.

5.6 Agencies that were deemed to have relevant contact were asked to provide an Individual Management Review (IMR) and a chronology detailing the specific nature of that contact. The aim of the IMR is to look openly and critically at individual and organisational practice to see whether changes could or should be made to agency policies and practice. Where changes were required then each IMR also identified how those changes would be implemented.

5.7 It was apparent that there had been very limited agency contact with either Beth and Zach and that information available to the panel was limited.

5.8 Essex University responded to the request for an IMR stating that they did not feel they held enough information on Zach to fulfil this requirement. After discussion with the chair, it was agreed that they would submit a chronology.

5.9 Zach's G.P. was contacted to provide further information around Zach's mental health but had no information regarding this as Zach had accessed private healthcare services.

5.10 Zach was under both a psychiatrist and a psychologist, from two separate private practices. Both practices were contacted with a request for information but only one responded.

5.11 Zach's psychiatrist initially provided only dates of appointments but on further enquiry agreed to provide clinical notes from his reviews.

5.12 There was no inquest as Zach admitted to killing Beth, so no coroner information was available for review.

5.13 Beth's only family member available to contact was her step-grandfather who did not wish to be involved in the review process.

5.14 The chair spoke with the mental health team who were undertaking Zach's care on several occasions. They were unable to provide any information that was of relevance to this review.

5.15 The chair discussed the possibility of meeting with Zach, but it was felt by his mental health team that he was too unwell.

5.16 Consideration was also given to contacting Zach's family, however, from the information provided by police, they did not appear to have any further information that would have been of use to the panel as they had little involvement with Beth or the relationship. It was felt that there was a risk of causing them distress and upset yet there was little they could provide from which any learning could be gained.

5.17 A partnership workshop was held on 8th March 2022 to consider the case and capture key issues for this report.

5.18 Due to questions raised at the workshop, this was followed up by a meeting between the chair and investigating officers to provide additional information.

5.19 No contact information was available for friends or Zach and Beth, yet consideration was given as to whether their insight would be useful to this review. However, their friends had already been questioned by police who were able to offer an insight into their perspective of Beth and Zach's relationship.

5.20 Information from records used in this review was examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the review is to prevent a similar crime.

5.21 This review began in February 2021 and was concluded in May 2022. Reviews should be completed, where possible, within six months of commencement. There were some delays in trying to ascertain where information was held, the information gathering process was also delayed due to back-logs and some delays were experienced due to agencies being required to divert resources to respond to Covid-19 pandemic.

6. Involvement of family, friends and wider community

6.1 Beth's mother had passed away in recent years due to health problems, Beth's grandmother had cared for her following her mum's death but had also recently passed away.

6.2 Beth's step-grandfather was identified as her closest family member, he was contacted by Police Family Liaison Officers, at the chair's request, who passed a letter to him introducing and setting out the purpose of the review, the letter included the Home Office prepared leaflet for family and friends, as well as details about AAFDA.

6.3 Beth's step-grandfather initially agreed to engage with the review but then declined when told it would have no bearing on the criminal case.

6.4 Police were able to provide information and insights from interviews with friends of Beth and Zach.

7. Contributors to the review

7.1 The following agencies contributed to this Review through submitting an Independent Management Review, a Chronology, and/or Summary Report:

- Essex Police
- University
- Sutton CCG
- North East Essex CCG
- Dyad Medical. Private Psychiatric Clinic

8. Review Panel

8.1 The panel for this review was made up of the following representatives:

Joanne Majauskis	Independent Chair
Val Billings	SETDAB Domestic Abuse Coordinator
Lisa Hobson	Colchester Safer Partnership
Jane Whitington	North East Essex CCG
Scott Kingsnorth	Essex Police
Matthew Dawson	GP Surgery (Colchester)
Tendayi Musundire	Essex Partnership University NHS Foundation Trust (EPUT)
Bev Jones	Next Chapter
Claire Beacham	Phoenix Futures

9. Domestic Homicide Review Chair and Overview Report Author

9.1 The Southend, Essex and Thurrock Domestic Abuse Board appointed Joanne Majauskis as DHR Chair and Overview Report Author in May 2021.

9.2 Joanne is an independent consultant and trainer with 15 years' experience working in the Domestic Abuse Sector. Joanne has experience of working both in frontline and strategic management roles. Joanne has also Lectured for the National Centre for the Study and Prevention of Violence and Abuse (NCSPVA) at the University of Worcester having completed her Masters in Dynamics of Domestic Violence with Distinction in 2015.

9.3 Joanne completed Independent Domestic Abuse Chair Training with Advocacy After Fatal Domestic Abuse (AAFDA). AAFDA are a Centre of Excellence for Reviews after Fatal Domestic Abuse and for Expert and Specialist Advocacy and Peer Support.

9.4 Joanne has been working Independently for two years is not employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

10. Parallel Reviews

10.1 There is no criminal trial as Zach has pled guilty to manslaughter by reason of diminished responsibility. Zach was sentenced in July and given a life sentence for manslaughter and ordered to serve a minimum of 12 years.

11. Equality and Diversity

11.1 Equality and diversity were considered throughout this review. The nine protected characteristics in the Equality Act 2010 were assessed for relevance: disability, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sexual orientation and age.

11.2 Although not directly a protected characteristic, it is of significance that Zach has a diagnosis of obsessive-compulsive disorder and had been receiving clinical care for his mental health. Zach has pled guilty to manslaughter by reason of diminished responsibility due to this. Studies suggest a significant positive correlation between mental health diagnoses in men and aggressive perpetration; males meeting probable diagnostic classification report significantly more frequent aggression than males not meeting diagnostic classification (Sesar et al, 2018; Shorey et al 2012). Mental Health is also identified as a high-risk factor on the Domestic Abuse, Stalking, Harassment and Honour based Violence (DASH) Risk Assessment. The review identified Zach's mental health as significant in the Terms of Reference and this will be considered throughout the report.

11.3 Gender is significant and should be given consideration in all Domestic Homicide Reviews'. Gender is considered a risk factor as the overwhelming majority of victims of domestic abuse are female with the perpetrators being overwhelmingly male. Statistics show that the majority of intimate partner homicides are disproportionately perpetrated by men on women (ONS, 2020).

11.4 Age is also of relevance in this case, as both Beth and Zach were only 21 years old at the time of the murder. Research indicates that women aged 16-24 are most commonly abused by an intimate partner (ONS, 2016). Accounts suggest that this was the first intimate relationship for both Zach and Beth.

11.5 Although it does not form a significant part of this review, Religion was also considered in this case. Zach and his parents are Muslim and police information says that Beth was not accepted by Zach's parents as she was not. Beth was not welcome in the family home, and this may have caused tension in their relationship although this is not known.

11.6 There is no evidence to suggest Beth was discriminated against either directly or indirectly by any of the statutory agencies with whom she came in to contact. However, Beth was an

American citizen and as such may have encountered barriers in knowing where or how to access services. She may also have faced limitations due to her financial status (Zach supported her financially as she was not permitted to work in the UK).

12. Dissemination

The following have reviewed the report in draft form, and/or will receive a copy (or notification) of publication:

- The family of Beth
- Senior managers of all participating agencies
- Workshop attendees
- Safer Colchester Partnership
- Southend Essex and Thurrock Domestic Abuse Strategic Board
- The Office of Police, Fire and Crime Commissioner
- DA Commissioners Office

Section Two - The Facts

13. Introduction to the Facts of the Case

13.1 Beth was found deceased in January 2021 by police following a 999 call from Zach's father. Zach's father contacted the Metropolitan Police Service to say that his son had telephoned from Colchester to say that he had stabbed someone, and they were dead on the floor. He described his son as paranoid and stated he was concerned that Zach may have hurt someone.

13.2 Essex Police attended the address where on arrival they found Beth with stab wounds. Despite the efforts of the officers and paramedics Beth was declared deceased.

13.3 Zach was the only other person present at the address and was arrested on suspicion of murder. At the time he stated, 'I didn't mean to do it'.

13.4 Zach was charged with her murder.

13.5 In September 2021 the case was heard at Chelmsford Crown Court where the Crown accepted a plea of guilty from Zach to the offence of manslaughter by reason of diminished responsibility.

14. Chronology

14.1 This chronology covers the period from 5th October 2019 up to the date of the homicide.

Combined chronologies

14.2 20th September 2019 –Zach receives a welcome email from the University of Essex Student Wellbeing and Inclusivity Service (SWIS). This is an introduction to his allocated wellbeing adviser and includes information on where he can access help and support pertaining to his mental health.

14.3 28th September 2019 – Zach is seen at Dyad Medical, Private psychiatric clinic. Zach had previously accessed the clinic and was seen several times during 2018 but stopped attending appointments and was discharged in July 2018. Zach reattends stating that his OCD has not improved, and he wants to restart medication as although he previously thought it didn't help, he realised once he stopped taking it that it was. Zach is given a care plan, a prescription for Clomipramine and a follow up appointment for November that he doesn't attend.

14.4 5th October 2019 – Zach makes a 999 call to Essex Police at 03.47 to report that Beth has "gone crazy and punched him in the face." A female (assumed to be Beth) is heard crying and pleading in the background. A THRIVE (Threat, Harm, Risk, Investigation, Vulnerability, Engagement) assessment is completed and police attend the scene 04.23. On arrival Zach tells officers that he and Beth have had a verbal altercation, which led to her pushing him lightly once. He confirms that he has not been punched. Both parties had been out drinking. Zach does not support further police action and provides a statement to this effect. A risk assessment is completed and graded as Standard risk. Zach is provided with a Domestic Abuse Support advice leaflet.

14.5 2nd November – Zach is seen at his GP surgery in Sutton and diagnosed with an upper respiratory tract infection.

14.6 16th December 2019 – Zach makes an initial request to the University of Essex (SWIS) for Individual exam arrangements (IEAs) due to his obsessive-compulsive disorder. This is followed up by an email from his wellbeing advisor suggesting they have an initial meeting to explore available support options.

14.7 23rd December 2019 - University of Essex (SWIS) Zach completes an 'Assessment of Needs' as evidence of his condition and applies for a Disabled Students Allowance (DSA). This is again followed up by an email from his wellbeing advisor with details of his Individual exam arrangements.

14.8 15th January 2020 – Zach's DSA is approved, and he is awarded 30 hours of one-to-one mentoring and specialist equipment (printer and scanner) via the University of Essex (SWIS)

14.9 22nd January 2020 – Zach's wellbeing advisor from the University of Essex (SWIS) emails Zach again to offer to meet and includes information on support services.

14.10 26th October 2020 – Zach attends Colchester GP Surgery with a painful lower back that he says he has had for three weeks after he hit his bottom against the bed while having sex under the influence of alcohol. Zach is diagnosed with contusion to his coccyx and advised on self-management with analgesia.

14.11 27th October 2020 – Zach reattends Colchester GP Surgery and is diagnosed with pilonidal sinus as his injury has worsened. His wound is cleaned and packed and antibiotics (Flucloxacillin) and analgesia provided (co-codamol 30/500).

14.12 28th October – 19th November 2020 – Zach receives daily and then alternate daily dressing changes. He is given pain medication. Nothing of significance to the review is mentioned in his notes.

14.13 11th December 2020

2.21 Zach checks into the Wivenhoe House Hotel which is located within the University Campus.

14.14 **2.50** The night security at the University file a report stating that they received a call from the Wivenhoe House Hotel night porter with concerns about a resident at the hotel who they had recognised as being a student living off campus (Zach). They said he appeared distraught and was possibly suffering from Bipolar. They confirmed he was not a problem but made comment to his mental health and the fact he hadn't slept for a few days. He told them that his girlfriend and friends try to help him but do not understand what he is going through. The hotel had offered to request patrol officers to speak to him, but he did not want this. He had then gone to his room for the night. The report was made to make staff aware of Zach's mental state and due to concerns that Zach's friends might report him as missing.

14. 15 **9.34** Following the report of concern for Zach's wellbeing, his University of Essex (SWIS) wellbeing advisor tries to contact Zach by phone to offer support. He doesn't receive a reply so follows up via email including full information on support available.

14.16 **10.30** Zach checks out of the hotel.

14.17 **23.25** The night security supervisor at the Wivenhoe House Hotel makes a non-emergency call to Essex Police control room to report that Zach had checked into the hotel the previous night. She was aware that he resided nearby and therefore thought it unusual that he had booked into the hotel. At the time he arrived he was distressed, and the timing coincided with reports of a local murder, so she wished to make police aware as she perceived his behaviour as suspicious (this was an unrelated homicide). The information given to the police indicated that Zach was known to suffer with bi-polar and so suggested that an alternative explanation that he may have been experiencing an episode at the time he booked in.

14.18 12th December 2020

00.55 Wivenhoe House Hotel calls the police and University to advise that Zach has reattended and booked back into hotel but given a fake address. The manager on duty recognised Zach from the previous evening and ask University security to attend. On arrival they report that Zach is abrupt but gives his correct address. The hotel agrees to let him check in.

14.19 **01.52** Police receive a 999 call from one of Zach's friends. She tells police that she is concerned about Zach as he is acting unpredictably and that he had been "arguing with his girlfriend and acting very strange". She reports that Zach suffers with mental health, depression and anxiety. She advises police that Beth is currently visiting a friend, Zach had been with her but had left with a friend to go to back to the Wivenhoe House Hotel. She says that she is concerned about the friend due to Zach's state of mind. This is logged as 'Concern for Welfare' and graded priority response three (attendance within an hour). A THRIVE

assessment is completed, and the risk categorised as high with Zach noted to be 'having an episode'.

14.20 **02.48** The hour response is not met (no rationale is given). The police incident log is updated with a request for the informant and ask what the concern was.

14.21 **03.07** The police log is updated with further information from the informant. She says she believed Zach was having a mental health episode, she had called an ambulance but was advised to call police. She expresses concerns about what Zach may do to himself and to the friend who is with him.

14.22 **03.08** The police control room call the ambulance service, there is an estimated delay time of seven hours. The control room call staff at the Wivenhoe House Hotel to update them.

14.23 **04.25** Staff at the Wivenhoe House Hotel call the University to say that the ambulance service has called them to say that a guest at the hotel needed an ambulance, but they are unable to contact him. The hotel asks the university security staff to attend. The hotel manager and security go to Zach's room, but he tells them to go away. He confirms that is ok but just wants to go to sleep.

14.24 **08.19** The police control room receive an update from the ambulance service stating that Zach had called them to say he did not want an ambulance, he wanted to sleep. It is recorded that 'he seemed quite angry'.

14.25 **08.27** A further update is made to the incident record highlighted that police needed to deal with the domestic aspect from the original report.

14.26 **09.04 – 10.50** Police attend Wivenhoe hotel and speak to Zach who says he wanted space from everyone. He was feeling down but did not wish to harm himself. A DASH risk assessment is completed and graded as standard.

14.27 The officer attempts to visit Beth but she is not at either of the addresses that they have for her on the system.

14.28 Police mange to contact Beth by phone. She states she is not sure why police are involved but that she was worried about Zach.

14.29 14th December 2020 - University of Essex (SWIS). Zach's wellbeing advisor makes contact with him by phone. Zach confirms that he is fine now and just needed some time to himself and to have quiet and sleep. He says that he is safe and has no support needs currently. A follow up email is sent with full information on support available.

14.30 January 2021 - Zach's father calls the Metropolitan Police to report his son had called him to say he had stabbed someone and they were dead. Police attend and find Beth with stab wounds and Zach as the only other person present.

14.31 19th January 2021 – Police inform the University that Zach has been arrested but this does not include information on the nature of the arrest.

14.32 1st February 2021 - University of Essex (SWIS) Zach's wellbeing advisor sends Zach an email reminding him of the available support services.

14.33 8th February – Beth was due to return to America.

Section Three - Overview and Analysis

15. Summary of Information known to Agencies, Family and Friends

15.1. The overview will summarise information provided by the agencies involved during the period under review.

Essex Police

15.2 Essex Police had three contacts with Beth and Zach in the time under review. Although, the second and third incidents on 11th and 12th December 2020, are a continuum.

15.3 The first contact was in October 2019 and was classified as a Domestic Abuse incident. Zach phones police to report an argument with Beth, stating that she has 'gone crazy and punched him in the face. A female can be heard crying and pleading in the background.

15.4 Police attend and Zach tells them that he and Beth went out for the evening and ended up arguing over a minor issue. When they got home the argument continued and during this Beth pushed him several times. There are no injuries. Zach says he got carried away in the heat of the moment, as he had drunk alcohol, and as a result he called police. He confirms Beth did not punch him. Both had been drinking but presented as calm and polite.

15.5 Zach does not support police action. Zach doesn't want to complete a risk assessment and the incident is assessed as standard risk with the justification recorded as, 'Minor incident, victim not vulnerable, no children, suspect no trace Police National Computer (PNC), no previous domestic abuse history either reported or unreported, victim unsupportive. A victimless prosecution is considered but is judged to be disproportionate and unlikely to succeed given the absence of corroborative evidence.

15.6 An Athena Investigation report (crime) is created for an offence of Assault without Injury (common assault and battery). Zach is recorded as the victim, with Beth shown as the suspect.

15.7 The second and third contacts both occurred on 11th and 12th December 2020. On the 11th Essex Police received a third-party report raising concerns in relation to Zach and a short while later on 12th December a further report also relating to Zach, which included reference to a domestic incident involving Zach and Beth.

15.8 The first call at 23.25 on 11th December is a non-emergency call from the night security supervisor at the Wivenhoe House Hotel. The purpose of the call is to provide information concerning Zach and a recent murder in the Colchester area.

15.9 The caller tells police that Zach checked into the hotel at 2.21am. Staff at the hotel know that Zach is a student. She says that they thought it unusual that he had checked into the hotel as they are aware that he lives nearby. Zach is described as being quite distressed at

the time he arrived at the hotel. The caller is aware that the hotel is not far from the scene of a murder that had occurred the same night and therefore wanted police to be aware.

15.10 Although not explicitly recorded on the log it would seem that the night security supervisor saw a potential coincidence in the timing and location of the murder and Zach's attendance at the hotel as well as his demeanour on arrival. She caveated the information provided by also stating that Zach suffered with bi-polar and so he may have been having an episode.

15.11 Police receive a further non-emergency call from security staff at the Wivenhoe House Hotel at 00.57 on 12th December advising that Zach had checked back into the hotel, for a second night running, in the early hours.

15.12 Police receive a further call from a friend of Zach at 01.52. She reports that she is concerned for Zach due to his actions being unpredictable. She tells them that he has been 'arguing with his girlfriend and acting very strange'. He had been with Beth at a friend's house but had left to go to the hotel with another friend. Beth had remained behind. The caller expresses concern for the friend Zach is with due to Zach's state of mind.

15.13 The police control room call an ambulance but there is a seven-hour response time. Zach later calls to cancel the ambulance.

15.14 At 05.03 incident log is updated by a police control room staff member to highlight that whilst the ambulance service is now dealing with the concern aspect of the call the initial information also made reference to a possible domestic dispute between Zach and Beth which needs to be dealt with by police.

15.15 Police attending the hotel speak to Zach who says he is fine and does not wish to harm himself. Zach tells the officer that he suffers with depression and that he had driven up from London to see his girlfriend and see if she was alright. He advised her that he needed a bit of space and stated she believed he had been acting erratically. He says they had only had a verbal argument.

15.16 A DASH risk assessment is completed with Zach, but the majority of responses are unanswered, and it is clear Zach did not cooperate with the assessment process. The DASH assessment is 'Standard Risk' based on the limited information the attending officer was able to ascertain through observation and conversation. Of note is the question relating to depression and suicidal thoughts, where the following is recorded, 'Zach is feeling depressed and is not currently on medication.' The officer gives Zach advice on keeping himself happier and Zach agrees that he will see his G.P. about getting help.

15.17 It is also recorded in the officers' notes that Zach has confided that he may well be ending the relationship as he does not feel it is working anymore.

15.18 The officer dealing with the call also speaks to Beth by phone having been unable to locate her the addresses on the system. Beth tells them she is not sure why the police have been involved, but says she was worried about Zach as he appeared to want to spend time on his own.

15.19 The Athena non-crime investigation log records the suspect as Beth and the victim as Zach. The subsequent updates in the investigation log reflect this attribution of culpability throughout the record, whilst at the same time recording that no offences have been identified.

DYAD Private Medical Clinic

15.20 Zach Started attending the Dyad Medical Clinic in January 2018. DYAD Medical is a private psychiatric clinic based in Harley Street. Zach had monthly appointments until June 2018 after which he stops attending. He reattends in September 2019 but doesn't attend his follow up appointment and is discharged in December.

15.21 Prior to attending the clinic, Zach had been seeing a clinical Psychologist for Cognitive Behaviour Therapy for five months. She had diagnosed him with obsessive compulsive disorder and had been working with him around his OCD symptoms. However, Zach felt there had been a deterioration in his mental health and wanted to have a psychiatric assessment at the clinic to consider taking medication.

15.22 Zach attended the clinic with his parents who attend the last part of the assessment only. He tells the psychiatrist that he 'pauses' when he is doing anything and everything in order to feel that things are right, before he can resume what he is doing. Zach says this affects his ability to revise as well as other areas of his life. Zach also says he can't touch certain things at home because if he does he feels that he needs to wash his hands straight away. He says he currently washes his hands around twenty times a day.

15.23 Zach says that his pausing affects his schoolwork. Two years prior to attending the clinic Zach sat his GCSE's and scored 11 A*s in additional to a B in additional Math. However, he states that when he sat his A levels he scored B in Biology, and 2 D's in Math and Chemistry. He tells the psychiatrist that he knew a lot of the answers but the 'pausing' prevented him from answering.

15.24 At his first assessment the psychiatrist suspects Zach may have autism spectrum disorder due to his presentation and suggests he is assessed for this. Zach starts the assessment but never completes it. This is discussed at all of Zach's subsequent appointments with the psychiatrist strongly recommending each time that Zach complete the assessment although he never does.

15.25 Zach is prescribed Clomipramine 100mg which over the course of his time under the clinic is increased to 250mg. Zach doesn't feel the medication helps and at his last appointment in June a plan is put in place to transfer his to another medication, Escitalopram.

15.26 Zach is asked at every appointment about suicidal thoughts, thoughts of self-harm thoughts, or any thoughts to harm others and he denies this on each occasion. He also denies experiencing any abnormal mode of perception, paranoid thoughts, thought alienation or ideas of reference.

15.27 At each appointment Zach is also asked if he consumes drugs or alcohol, he answers no to both each time. However, when he returns to the clinic in Sept 2019, he still answers no to drugs but says that he drinks alcohol 2-3 times a week, consuming an average of eight units each time.

15.28 Zach reattends the clinic in September 2019 stating that his OCD is no better and wishes to restart medication as retrospectively he realised it was helping. He attends the appointment with his 'American girlfriend'. When asked he states their relationship is good.

University of Essex Student Wellbeing and Inclusivity Service (SWIS)

15.29 Zach had previously been enrolled to City University to study Computer Science for six months but didn't like it so left and enrolled in the University of Essex to study Psychology.

15.30 The Student Wellbeing and Inclusivity Service (SWIS) made contact with Zach when he joined the University in September 2019. Zach was allocated a caseworker due to his OCD diagnosis.

15.31 The SWIS wellbeing caseworker had several interactions with Zach between September 2019 and January 2020 regarding special dispensations for Zach and providing support numbers and information about services Zach can access. There are no further interactions until December 2020.

15.32 The caseworker offered to meet with Zach in person on more than one occasion, but Zach does not appear to have accepted this offer.

15.33 Following the incidents at the Wivenhoe House Hotel on the weekend of 11th-12th December. Zach's wellbeing caseworker contacts Zach by phone who confirms he is safe and well. This is followed up by an email with support information and a reminder that Zach can contact his caseworker if he needs support, guidance or a listening ear.

15.34 On the 19th January, the University is notified by police that Zach has been arrested, but do not give details of the nature of the arrest.

15.35 Zach's caseworker emails him on 1st February reminding him that him of the available support services and that he can make contact if he needs support.

Sutton CCG (G.P. Surgery)

15.36 Zach was registered at a G.P. Surgery in Sutton for seven years between 2013 and 2020.

15.37 During the time under review Zach had only one interaction with the surgery when he presented with symptoms suggestive of a viral upper respiratory illness for which he was given general advice.

15.38 However. the surgery provided relevant information from before that period for the interest of the report.

15.39 Whilst registered at Manor Practice Zach had a diagnosis of obsessive-compulsive disorder. This was first entered onto his record on 15th January 2016., following a face-to-face review with the G.P. where Zach reported having "thoughts that don't make sense". He had "no morbid thought of self-harm or violence but was worried that these erratic thoughts were affecting his concentration and hence his studies".

15.40 Zach was referred to local mental health services and prescribed Citalopram 10mg (a serotonin selective reuptake inhibitor, antidepressant). Zach felt these didn't help and was changed to Sertraline (another SSRI) although the notes suggest it doesn't appear this was taken.

15.41 Zach was seen on another couple of occasions in June 2017 by an out-of-hours GP and signposted to Sutton Uplift, MIND and Sutton carers centre and again in January 2018 when he was referred directly to Sutton Uplift by a doctor at Manor surgery.

15.42 Zach underwent a phone assessment by the Sutton Uplift in January 2018, and they advised his depression and anxiety scores were moderate/severe – PHQ-9: 12, and GAD-7: 16) respectively. He was offered a course of computerised cognitive behavioural therapy.

16. Overview and Analysis

16.1. This part of the review will examine how and why events occurred. It will consider whether different decisions or actions may have led to a different course of events. The analysis section considers the previous sections within this report, the content of the IMR's, and the chronology of events.

16.2 This review is not looking into the cause of Beth's murder but seeks to address the terms of reference. The purpose of the review is to examine the contact Beth and Zach had with services and analyse whether those services were appropriate and whether there are lessons to learn from this tragedy, including identifying good practice.

Thematic Analysis

16.3 The questions raised in the terms of reference have been grouped into three main themes for the purposes of analysis: the information that agencies held about Zach's mental health and whether they had knowledge of any risks this may have posed, whether any agency was aware of coercive control in Zach and Beth's relationship and agency responses to domestic abuse. These themes are discussed below. Whilst not a theme of this report, given the period of time during which the murder took place it is also important that we consider whether the pandemic could have had any bearing on this case.

Information regarding Zach's Mental Health and potential risks

16.4 Some studies suggest a correlation between obsessive compulsive disorder and violent obsessions or 'anger attacks' (Cludius et al, 2020; Zhang et al, 2019; Terrence et al 2017; Prakash Painuly et al, 2011). It was, therefore, considered by the panel whether any agencies may have held information about Zach that could have indicated that he may have been a risk to himself or to others.

Healthcare

16.5 Zach's G.P. surgery in Colchester held very little information about him. The majority of their contacts related to dressing changes and no concerns were picked up by the nurses during their interactions with Zach.

16.6 The previous GP surgery Zach was registered with in Sutton held much more information about Zach's mental health in their case notes. However, the two surgeries used different systems; 'EMIS' and 'System One'. It appears that there was a breakdown and lack of information sharing between practices on EMIS/ System One. It was discussed at the panel

meeting that it is a reoccurring issue that EMIS and System One don't 'talk to each other' particularly well.

16.7 Zach's current G.P. Surgery in Colchester had no information in their records that would have alluded to Zach having a mental health diagnosis. Whilst within the other practice's records there were mentions of OCD, Bipolar and references to depression. Nothing was recorded on System One.

16.8 Neither G.P. surgery held any information that indicated that Zach may have posed a risk to himself or to others.

16.9 Zach was also seen privately by a psychiatrist located in Harley Street. There is no mention in the case notes, provided by the clinic, to suggest that Zach ever displayed any behaviour that could be regarded as concerning or that could have alerted his psychiatrist to any violent act. In fact, Zach was asked about intrusive thoughts and thoughts of wanting to harm himself or others at every visit and denied this.

16.10 The plan provided by the clinic informed Zach that should he have a deterioration in his mental health, any side effects from his medication or have any thoughts of harming himself or others, he should call the clinic, his G.P. or present to A&E.

16.11 From the information provided to the review, we are also aware that Zach was receiving cognitive behaviour therapy from a private psychologist. They were approached and information was requested but they declined to provide this.

University

16.12 It would appear that Zach self-referred to the University wellbeing team on enrolling at the University of Essex. The University confirmed that professionals are normally only aware of the information the student gives them.

16.13 Zach's wellbeing advisor did request medical evidence of his condition from his healthcare provider or G.P. on a couple of occasions but it is not apparent whether Zach ever provided this. Zach had requested extensions to exams which are usually evidenced by G.P. reports but the G.P. records show that no extenuating circumstances had been submitted to the University.

16.14 It is apparent that the wellbeing team had very little information regarding Zach's mental health. Despite efforts to engage Zach. his wellbeing caseworker did not appear to have much contact with Zach.

16.15 It was discussed by the panel that University staff and staff from the Wivenhoe House Hotel seemed to have an awareness of Zach's mental health diagnosis. During a call to police when Zach attended the Wivenhoe House hotel, staff from the hotel informed them that Zach was Bi-polar. Zach had not been diagnosed with Bi-polar, but it does suggest that the staff member had some knowledge of Zach and the fact he had a mental health diagnosis although again information held by them appears to be limited.

Police

16.16 The first incident when Zach and Beth come to the attention of police is logged as a domestic incident. Officers attended and Zach would have been asked about his mental

health as part of the DASH risk assessment process, but he declined to complete it. Both Zach and Beth are described as calm, by attending officers, and there was no reference to or identification of mental ill health as a factor. Rather the consumption of alcohol appears to have been the identified as a potential catalyst to the incident.

16.17 During the events that took place on 11th-12th December Police were made aware that Zach was experiencing poor mental health. The initial call from staff at the Wivenhoe House hotel was to provide information around Zach's 'unusual behaviour', and the possibility he may have been involved in a nearby murder. During this call the staff member also informed Police that Zach suffered with Bi-polar, which was given as a possible explanation for his behaviour. There is no evidence to suggest the call handler explored this any further. However, in both this call and the follow up call the hotel make, to tell police Zach had checked back into the hotel, nothing is recorded that indicates security staff had any specific concerns about Zach's behaviour or welfare at the time.

16.18 The first indication police receive that suggests Zach may be a risk to himself or others is from the call they receive from Zach's friend. to report that Zach had been arguing with Beth. In this call she says that he been acting strangely, his behaviour was unpredictable and expresses a concern that he presented a risk of harm to either himself and/or others; specifically; at that time another friend who he was going to the hotel with.

16.19 During the call the friend states that Zach has recently taken drugs, is acting 'really really strange' and aggressively. They also share that Zach has previous mental health issues including OCD, depression, and anxiety. The friend alludes to 'grandiose behaviour and says that Zach ''believes he is God' implying possible psychosis, delusions and potential feelings of superiority and invulnerability. This information was not explored by the Call Taker which was potentially a missed opportunity to gather more information.

16.20 During the call, the friend also states that Zach's condition has worsened, so they are worried about what he might do next. The caller tells police that Zach was shouting at Beth to 'force her to come with him. Beth refused to go, which the caller described as being against Zach's will. They go on to say they are concerned about what Zach's actions are going to be because of his "manic episode and grandiose outlook right now".

16.21 The incident log references mental health, depression, and anxiety and references 'Zach reported to be having an episode', but it is unclear to what extent any potential delusional behaviour and any associated risk were considered.

16.22 The call is graded as priority response 3 (response within one hour) and a THRIVE assessment completed that assesses the risk as high. Whilst the police IMR and review concur with the grading of high risk, it states that the assessment lacked detail about what the risks could be and to whom. These included the potential for Zach to return to the address where it was said Beth remained. To his friend, himself or to hotel staff. Nor were specific risk levels applied to each person identified (e.g. 'Friend – High', 'Girlfriend - High', 'Staff – Medium', 'Zach – Medium', 'Guests – Standard', 'Public – Standard').

16.23 A STORM incident log was created and was allocated the header 'Concern for Welfare'. The review considers that the use of a 'Domestic Abuse' header would have been more appropriate given the information that was shared about Zach and Beth. This will be explored further in the section on 'response to DA'.

16.24 The grade three hour target to respond to the call was not met. Whilst, it is clear that during busy times demand may outstrip capacity meaning it is not be possible to meet response times, best practice requires the incident log to be updated detailing why it has not been possible. No such entries are present on the log in this case.

16.25 Where response times aren't met, a call-back should be made to the informant to check on welfare and provide reassurance. In this case, just prior to the hour mark, the incident log was updated with a comment requesting a call be made to the informant, but with the purpose of clarifying the nature of the concern raised. The need for such a call is not immediately apparent as the concerns raised were clear from the initial call. Although not recorded as such on STORM, it could be that the call-back was in part intended to establish if there was any change in circumstance or risk.

16.26 The call back to the informant confirmed the concerns highlighted in the original call i.e. a concern for both Zach and his friend. The call also identified that the informant had called the Ambulance Service prior to calling Essex Police. Having raised her concerns to them the Ambulance Service had advised her to call police. This new information resulted in a decision to contact the Ambulance Service with a request for them to respond. The STORM incident log is subsequently updated with the ambulance incident reference and a note to say ambulance have graded the incident as a Grade 4 and there is a 7-hour delay time.

16.27 There is nothing recorded in the police log to suggest the THRIVE risk assessment had been reassessed or downgraded at this point. Therefore, given the THRIVE assessment of High, the police review concluded that it was not appropriate to refer the incident to the Ambulance Service without having engaged with Zach or Beth.

16.28 Approximately three hours after the initial call to police, a control room staff member highlighted on the STORM log that there was a domestic abuse element to the incident which police needed to deal with. Again, this will be explored further in the section on 'response to DA incidents'. At this point the incident was still being categorised as a 'Concern for Welfare' and remained a Priority Grade 3.

16.29 At 09.04am, just over seven hours since the original call was made, an officer attended the Wivenhoe House Hotel and spoke with Zach. An Athena Investigation report (non-crime) was subsequently opened showing the Victim as Zach and the Suspect as Beth.

16.30 The attending officer sought to complete a DASH risk assessment with Zach, which he declined to co-operate. The officer completes the risk assessment based on their conversation and his observations, of note is the question relating to depression and suicidal thoughts, where the following is recorded, 'Zach is feeling depressed and is not currently on medication.' The officer notes that Zach says he is feeling down but does not wish to harm himself. The risk identification was recorded as Standard. Advice was given by the officer in respect of Zach's mental health and Zach agreed that he would contact his GP.

16.31 Zach was not asked if he would be willing to provide his GP details and no information was shared by Essex Police with his G.P. This could have been a useful additional step, had Zach been willing to provide such details.

16.32 The officer also spoke with Beth by telephone, having unsuccessfully tried two addresses looking for her. She did not raise any concerns for herself nor make any allegations against Zach. The officer described her as being more concerned for Zach and his state of mind than

anything else. She was unsure as to why the police had been called. She stated she had been worried about him leaving and being on his own given his state of mind at the time.

16.33 Given the information available and the manner in which Zach presented the actions taken by the attending officer with regards to mental health appear to be proportionate.

16.34 Police do have access to a Mental Health Street Triage (MHST) team in Essex to support officers attending incidents where someone may be in mental health crisis. The team consists of trained police constables and mental health nurses from Essex Partnership University Trust (EPUT). However, this was not an incident where it would have been deemed necessary to seek further advice from MHST.

Coercive and controlling behaviour

16.35 There was very little information about the nature of Zach and Beth's relationship available to the panel. Information provided by police was that Zach and Beth met online, and Zach first went to visit Beth in America approximately four years prior to her death. On this visit they booked into a hotel where they stayed together for a week.

16.36 During the course of their relationship, Beth had been to visit Zach in the U.K. four times. Zach paid for her flights and supported her financially on each visit. It could be hypothesised that Beth's financial dependency on Zach could have created an uneven power dynamic but this can't be known. During her stay, Beth was living with Zach at his student accommodation. This was during a time when movement and mixing with others was restricted due to the pandemic. This may have further exacerbated any control that Zach may have had over Beth.

16.37 When they weren't together, they would call each other daily. Beth's step-grandfather told police that he would hear them talking late at night. He stated that he would often hear her crying during the calls and saying, 'don't do that'. The context of these conversations is not known but this may indicate that the relationship had some issues.

16.38 The police file also indicated that friends of Zach and Beth refer to a 'deteriorating relationship' and indicate that Zach was controlling in the relationship. Despite the 999-call made by Zach to police in October 2019 police found no evidence to suggest Beth was abusive

16.39 In December 2020, Zach confided to police that he doesn't think his relationship is going well and he is planning to end it. However, information from friends suggests that in fact Beth may have been in the process of ending the relationship before returning to America in February. Separation is a known risk factor (Kelly, 2018; Richards, 2004) identified that the majority of women killed by a partner/former partner had separated or taken steps to separate.

16.40 Police intelligence suggested that Beth was very isolated although it was reported that his friends seemed to like Beth more than Zach. Her isolation may have been exacerbated by Covid as social distancing and restrictions on socialising were still in place during the time of their relationship. It is also known that Beth had lost close family members in recent years which could have created a dependency on Zach. Zach's family did not engage with Beth, she was not allowed to visit their home as they disapproved of her not being Muslim.

16.41 From the information available, it appears that Beth was more concerned about Zack's welfare rather than expressing concerns for her safety or that of others. It is not unusual in abusive relationships for the victim to take responsibility for the abuse or to feel responsible for the perpetrator's wellbeing. There are numerous reasons why victims become trapped in abusive relationships, in this instance, it is possible that one of those reasons was that Beth felt she could help Zack with his deteriorating mental health and exacerbating drug issues but that cannot be known with any certainty.

16.42 Friends also report an increase in Zach's use of drugs in the months leading up to Beth's death. They report he was using Cannabis and potentially Methylenedioxy methamphetamine (MDMA), commonly known as ecstasy and Lysergic acid diethylamide (LSD) They report that he was experimenting with micro dosing in an attempt to manage his OCD. Whilst a positive result was not indicated in the toxicology report following Beth's murder, it is reported that some substances do not always show up, so a negative test does not give a 100% indication that it had not been used.

16.43 Zach's drug use could well have exacerbated any abusive behaviour in their relationship. Research indicates that incidences of domestic violence are significantly higher in substance abusers than others and that there is an increased risk of homicide (Chopra et al, 2022; Potter, 2021; Bhatt, 2000; Dutton and Kropp, 2000).

Response to domestic abuse incidents

Police

16.44 Police were contacted on two occasions with regard to domestic incidents between Zach and Beth. The first incident on 5th October 2019 was when Zach called 999 to say Beth had punched him in the face. This was identified as a domestic incident requiring police attendance and the priority response grade 3 was applied. The Call Handler correctly assessing that there was a degree of importance or urgency associated with the call, but that an emergency response was not required.

16.45 However, the THRIVE assessment process, which concluded both Harm and Risk were 'minimal' is queried. The information received indicated both parties were still present together at the premises. A female voice can be heard crying and pleading in the background. The allegation is made of a physical assault involving the informant being punched to the face, with the description of 'the girlfriend' having 'gone crazy'. In these circumstances the potential for escalation and harm were greater than 'minimal'.

16.46 The police IMR also notes that the information recorded against each area of the THRIVE assessment is extremely limited to the point where it is questionable as to whether the THRIVE process has been applied effectively. However, the priority grading meant that a police unit arrived just 36 minutes after the call was first received and within the target response time.

16.47 On arrival officers were presented with a changed account from Zach who told officers that Beth and he had been arguing and she had pushed him lightly once. Zach indicated that he had overreacted in calling the police, stating he got carried away in the heat of the moment as he had drunk alcohol. No injuries were seen by the officers and both parties presented as calm. No counter allegations are recorded as having been made by Beth.

16.48 The apparent change of tone from the initial call to the account provided by Zach on police arrival begs the question as to whether officers were given a full and truthful account of the events that took place.

16.49 There are three versions of events recorded by police; that Zach was punched, as alleged in the initial 999 call. That he was pushed lightly once, as told to attending officers and a third version recorded on Athena suggesting multiple pushes.

16.50 The inconsistency between these three recorded accounts is not clarified by any account obtained from Beth. There is no record of any account she may have given of the events that took place. The only reference to Beth having spoken is contained within a supervisory comment on the Athena investigation log saying that she was making 'admissions' at the scene. Details of the admissions said to have been made by Beth are not recorded.

16.51 The absence of Beth's 'voice' in the log also suggests that Beth was not questioned about the crying or pleading that the call handler heard from a 'female' when the initial call was made. It is unclear whether Beth, although making some admissions, was able to convey fully her version of what took place. She is not recorded as making any allegations, but her status as the 'Suspect' meant she was not subject of a DASH risk identification assessment, meaning there was less opportunity to understand her perspective of the relationship and the drivers behind the events that occurred.

16.52 From the information recorded it is not clear what level of professional curiosity was applied in seeking to understand Beth's account and any drivers behind the events that took place. It is also unknown if officers sought to create the appropriate environment to enable disclosure to be made. It is not recorded to what extent other factors were considered, such as;

- whether Beth may have used justifiable force against the Zach in self-defence
- whether Zach may be making a false counter-allegation
- whether Beth was inhibited from making disclosure
- whether Zach could be a manipulative perpetrator trying to draw the police into colluding with his control or coercion of the victim, by making a false or exaggerated report.

16.53 As the identified victim, Zach was subject to the DASH risk identification process but declined to engage in this. The subsequent assessment was therefore incomplete but recorded the risk as 'Standard'. It is arguable that given the inconsistencies in account and Zach non-compliance the risk was actually 'unknown', however this is not an option available to officers. On this occasion there was nothing to indicate any likelihood of serious harm being caused so an assessment of 'Standard' risk would seem appropriate.

16.54 Checks were also completed by the Assessment Team and revealed no history of domestic abuse or previous offending by either party. Zach made it clear that he did not wish officers to take further action and that he did not support any form of prosecution. In accordance with force procedure the officers took a witness statement from Zach to this effect.

16.55 A victimless prosecution was considered by police, but the officer's notes highlight the evidential difficulties with progressing the case, including the following comment: 'I am minded that a victimless prosecution would be disproportionate in this instance. That said I do not believe this would meet the evidential aspect of the FCT [CPS Full Test Code] in any case, as apart from the suspect making admissions at scene, there is no other corroborative

material that would substantiate the alleged assault should there be a 'not guilty' plea at court.'

16.56 In the circumstances overall the decision not to arrest Beth or to pursue any form of judicial or nonjudicial disposal appears to be proportionate and appropriate in this instance.

16.57 The second time police were made aware of a domestic incident was on the night of 11th December when Zach's friend calls 999 to report her concerns. She states in the call that Zach had been arguing with Beth and had left the property they were at together but had wanted Beth to go with him and she had refused. The call also contains information about Zach's state of mind. concerns about his behaviour, and concerns for the friend he is with.

16.58 A STORM incident log is created and allocated the header 'Concern for Welfare' recognising the need to check on Zach's welfare but failing to identify the domestic abuse element of the call meaning that the incident was incorrectly categorised, with implications for how police subsequently responded.

16.59 The call contains the following key pieces of information, provided by the informant either in free recall or in response to the Call Handler's questions.

- Zach is described as manic and having left the address with another friend. There is a worry as to what he may do next because he is acting very unpredictably.
- Recently he has taken drugs and ever since then his behaviour has changed extremely.
- He believes he is God and he has been picking fights with all of his friends. He came over in a rush from London to Colchester and he was shouting at his girlfriend and has since left with one of his friends.
- The informant is worried about the friend who went with him, about his well-being, because Zach's actions are unpredictable.
- Zach has been acting 'really really strange' and he already has previous mental health issues like OCD, depression, and anxiety. His condition has worsened, and he's been acting aggressive, so the informant was worried about what he might do next.
- Zach has been diagnosed with severe OCD, he has depression and experiences anxiety.
- 'He took one of our friends with him, but he was previously shouting at his girlfriend to like force her to come with him.'
- Beth is still at the property because she decided not to leave with him. The informant described this refusal as being against Zach's will.

16.60 The information provided in the call signposted a number of potential risks. These included the potential for Zach to return to the address where it was said Beth remained. Given the nature of the call it should have been identified as a 'Domestic Abuse' incident', not a 'Concern for Welfare'. This oversight meant that Beth, whose safeguarding should have been an equal priority along with the concern for Zach's welfare, was not prioritised by police.

16.61 The failure to identify the incident as Domestic Abuse meant that Assessment Team tags were not automatically generated, and background checks were not completed. These would have identified the previous domestic assault in October 2019 and identified Beth as Zach's girlfriend.

16.62 It is more than three hours later, when the case is referred to the Ambulance service that a member of the control room staff highlight that the initial information made reference to a possible domestic dispute between Zach and Beth and that this aspect of the call needed to be dealt with by police. However, at this point Beth is wrongly identified as the suspect and Zach as the victim.

16.63 In this incident, Zach should have been identified as the perpetrator. He was described as acting aggressively, shouting at his girlfriend, seeking to force her to go with him, acting unpredictably and posing a potential threat to others. If the incident had been correctly categorised as Domestic Abuse and prioritised as a Priority 3 response, a police unit should then have attended the address where Beth was believed to be to ascertain her welfare and identify whether any offences had taken place.

16.64 In addition, had the incident been headed as Domestic Abuse (rather than Concern for Welfare) then when the one-hour response time was not met, the FCR Inspector would also have been required to endorse the incident as to why the priority grading could not be met. As it was recorded as a concern for welfare there was no requirement for this to happen and no explanation is given as to why the response time wasn't met.

16.65 Even after the call is highlighted as a domestic abuse incident, no action was then taken for a further three plus hours when the log was updated with information from Athena identifying Beth as being the girlfriend and involved in the previous domestic abuse incident in October 2019. This information was uploaded to STORM by a member of FCR staff, not the Assessment Team, the incident at this time still being categorised as a 'Concern for Welfare'. It remained a Priority Grade 3.

16.66 Police attend the Wivenhoe House Hotel and speak with Zach. An Athena Investigation report (non-crime) was subsequently opened showing the Victim as Zach and the Suspect as Beth. The attending officer sought to complete a DASH risk assessment with Zach, which he declined to co-operate with. The risk identification was recorded as Standard.

16.67 Although it cannot be known what might have been disclosed, had Beth been correctly identified as the victim in this case, the DASH risk assessment would have been completed with her and there may have been an opportunity to identify any hidden risks or controlling and coercive behaviour within her and Zach's relationship.

16.68 The attending officer did confirm that he also spoke with Beth by telephone, having unsuccessfully tried two addresses looking for her. Beth did not raise any concerns for herself nor make any allegations against Zach. The officer described her as being more concerned for Zach and his state of mind than anything else. She was unsure as to why the police had been called. She stated she had been worried about him leaving and being on his own given his state of mind at the time.

16.69 It would appear that several factors influenced the decision to record Zach as the victim and Beth as the suspect. The officer was aware that Zach was shown as the Victim in a previous domestic assault where Beth was recorded as the suspect. Zach was spoken to first by police, and consequently he was the person made subject of the DASH risk assessment. The officer also feels he may have been influenced by the fact that Zach presented as slightly vulnerable and struggling with his mental health, whereas Beth when spoken to sounded more self-assured and confident.

16.70 Although, having spoken to both with Zach and Beth there were no grounds to indicate any likelihood of serious harm. It is unclear whether the risks were fully understood. Zach did not cooperate with the DASH risk assessment and the decision to categorise Beth as the Suspect meant that no risk identification process was completed with her. There was therefore insufficient information obtained on which to base a reliable assessment of risk.

University of Essex

16.71 There is no evidence to suggest that the University would have had any knowledge of Zach and Beth's relationship or the nature of it. However, it is of note that the University have several policies and processes in place to support students should they be experiencing domestic abuse:

16.72 Report and support – a system which students and staff can use to report incidents of sexual violence, domestic abuse, harassment and hate crime. As soon as they have submitted a report, if they have requested support then a member of the wellbeing team contacts them, and actions are put in place.

16.73 'Bringing in the Bystander' All students are given an introduction to being an active bystander as part of the registration process. This is an intervention that was originally developed by the Prevention Innovations Research Centre at the University of New Hampshire as a workshop that teaches bystanders how to safely intervene in situations in which sexual violence, domestic violence or stalking are occurring or are at risk of occurring.

16.74 Bringing in the Bystander® already has a robust evidence-base, showing positive shifts in the likelihood of bystander action across a number of populations in both men and women (Cares et al., 2015; Moynihan, Banyard, Arnold, Eckstein, & Stapleton, 2010, 2011; Potter & Moynihan, 2011). The Prevention Innovations Research Centre report that 365 colleges, universities, health centres and coalitions now use the intervention across a number of different countries.

16.75 There is also a mandatory consent programme during registration for all students unless it is too upsetting for them.

16.76 The University also have worked with SETDAB and have previously supported the 16 days of action programme across campuses with different external agencies being invited to promote their organisations and the support they can offer to students.

Impact of the Pandemic

16.77 Although the pandemic has not been identified as a contributing factor in this case, it is important to acknowledge that at the time of the incident in April 2021 the COVID-19 pandemic was at its height in terms of impact on day-to-day life in England.

16.78 From the information provided by agencies for the purposes of this report it cannot be known whether the pandemic had any significant impact in this case, however, a heightened risk of domestic violence has been associated with infection-reducing measures undertaken by governments during the COVID-19 pandemic (Gulati and Kelly, 2020).

16.79 It is also widely reported that it had a detrimental impact on some individual's mental health (WHO, 2022). Some research specifically focused on individuals presenting with obsessive compulsive disorder and found that they may experience heightened levels of stress or anxiety symptoms during a pandemic, including fear of infection, fear of contact with contaminated surfaces, compulsive handwashing, and checking and reassurance-seeking associated with pandemic-related threat (Ameringen et al, 2022; Matsunga et al, 2020).

16.80 During this time, movement between countries had also been restricted due to the pandemic. This may have informed Beth's decisions on how long to stay and when to return, however, Beth didn't overstay and complied with requirements of her visa.

Section Four – Lessons Learnt

17. Conclusion

17.1 It is important that we highlight and identify both good practice as well as where things could be improved. It can never be known whether different actions would have resulted in a different outcome, but we hope that the lessons learnt, and the changes made as a result of this review are able to provide some comfort to those who knew Beth that others will be better protected. Our thoughts are with her family and friends.

17.2 There was little information available to the panel, but certain themes emerged that are addressed here and in the recommendations.

Essex Police

17.3 Given the nature of Beth's murder and the finding that Zach was suffering from diminished responsibility, it cannot be said that within the limited contacts Essex Police had with Beth and Zach there were any opportunities to disrupt his offending or change the course of events.

17.4 Neither of the domestic incidents that took place in October 2019 and December 2020 gave any grounds to indicate that Zach was capable of such actions or that Beth was at risk of serious injury. On both occasions the Standard risk assessments were appropriate and this was the only assessment that staff could have reached based on the information available to them. No safeguarding opportunities or referrals to partner agencies were missed.

17.5 Both incidents were recorded (STORM and ATHENA), assessed (THRIVE), prioritised (Grade 3 response) and attended by officers. Immediate safeguarding issues were addressed, vulnerability considered, and a DASH risk assessment completed. Enquiries were made and supervisory assessment applied. The Essex Police response was therefore appropriate and in line with procedure. However, there were elements of the response which could have been improved upon and this review provides some opportunity for learning.

17.6 With regard to victim/suspect identification, Athena currently allows for individuals involved in an incident to be classified as either a 'Victim', a 'Suspect', or an 'Involved Party'. With regards to Domestic Abuse investigations Essex Police do not currently support the use of 'Involved Party', requiring instead that officers identify and classify a 'Victim' and a 'suspect' in each case. This includes those investigations where no crime is identified. This practice reflects a concern that identifying the victim incorrectly would mean a DASH risk assessment not being completed with the right person, with the potential for safeguarding measures not to be implemented. Failure to recognise a 'Victim' may also lead to repeat victims being overlooked.

17.7 The dynamics of abuse are complex, and it may not always be clear who is the 'Victim' and who is the 'Suspect'. As such it is imperative that both parties are spoken to and that officers remain professionally curious and refer to guidance if unsure. Force Procedure B1702 Domestic Abuse Investigations – Paragraph 3.1.1 provides guidance to officers where it is unclear who is the victim and who is the perpetrator (appendix one).

17.8 In incidents where neither party claims to be the victim or there is no clearly identified victim or perpetrator and no identified offence, but where a domestic incident has taken place, risk can only be fully understood and the absence or presence of offending confirmed, through the completion of risk assessments involving both parties. In effect the DASH is used only after an officer has already determined status, rather than as a tool used in the overall investigative approach to determine risk, offending and the status of the parties involved.

17.9 Only post assessment should status be fully considered and in cases where no offences are identified, rationale should be provided on how the decision has been made in identifying who is the 'suspect' and who is the 'victim'.

17.10 The current approach does not encourage responding officers and investigators to maintain an inquisitive, investigative mindset, utilising professional curiosity and adopting a holistic approach to risk identification.

17.11 It is understood that the process of completing a DASH assessment can take time. In cases where it appears unlikely that an offence has taken place the completion of two assessments may be viewed as disproportionate use of resource, however a streamlined risk identification process could offer opportunity to accurately identify risks without placing further excessive demand on already overstretched frontline police resources.

17.12 In this case it cannot be said whether further assessment would or would not have identified any additional risks and in particular any risks which were not understood as at the time of Beth's murder and which would have enabled safeguarding interventions to be made. On balance, given the significant mental ill-health element to the homicide, this seems unlikely, but on the two occasions officers had contact with Beth there was at least an opportunity to assess risk. An opportunity that due to current working practices was not fully exploited.

17.13 It is important to reiterate that on both occasions Beth appears to have had an opportunity to raise any concerns and she did not do so. However, given the nature of DA offending and the potential for fear, intimidation, coercive and controlling behaviours and personal and cultural factors which may inhibit disclosure being made, it is important to provide every opportunity for such revelation. Engagement through completion of a structured risk assessment can be an effective means of doing this. Had this happened, Beth may have had

the opportunity to make a disclosure whereas officers could have offered her support in leaving the relationship.

17.14 This review therefore provides an opportunity to look again at how risk is holistically assessed, particularly in cases where DA is present, but no offence is identified or where there is no allegation made or allegations are not supported and there is no substantive criminal investigation.

17.15 The other learning point regards the control room response and THRIVE Assessment from the second incident in which police were involved with Zach and Beth. The initial failure to recognise the domestic abuse element of the call and respond appropriately indicates there is an opportunity to provide feedback to control room staff for personal learning.

17.16 In addition, the police IMR highlighted the cursory nature of the THRIVE assessments that took place. An opportunity exists to debrief the staff directly involved in these incidents, but also to share more widely the learning from this review as part of ongoing Continuous Professional Development (CPD) to control room staff. Training should emphasise the benefits of staff clearly identifying in detail the Threats posed, the types of Harm that may be caused and specifically who is at Risk. The objective being that the THRIVE process when applied correctly should assist in identifying the nature of the incident and determining the appropriate police response.

<u>Healthcare</u>

17.17 There is no evidence to suggest that either Zach's G.P. surgery or his private healthcare clinic could have had any indication that he was a risk to himself or to others. However, research into domestic homicide reviews highlights that mental health and substance misuse are present in the majority of cases (Potter, 2021) so this case does highlight the need to ensure that safety assessments are undertaken during mental health reviews and that screening for domestic abuse is imperative.

17.18 It is highlighted as good practice that the notes from Zach's private healthcare clinic evidence that on every contact he was asked about thoughts to harm himself or others. Enquiries were made as to the nature of his relationships and plans and guidance were given to Zach on what to do should his mental health deteriorate. Whilst tragically he did not follow this guidance there does appear to have been ample opportunities for him to make disclosures.

17.19 What is unclear is whether enquiries were made by the clinic into why Zach stopped attending and whether there may have been an opportunity to examine barriers that prevented him from continuing with his treatment through them.

17.20 This review also highlighted the issue of information sharing between G.P. practices when someone transfers to a new surgery. Zach's previous GP surgery held information about Zach's mental health in their case notes that was not known to his current surgery. Zach's current G.P. Surgery in Colchester had no information in their records that would have alluded to Zach having a mental health diagnosis. Whilst within the other practice's records there were mentions of OCD, Bipolar and references to depression.

17.21 Although, it is unlikely that had Zach's G.P. surgery had knowledge of his mental health issues it would have had any bearing on this case, it does show that there the breakdown

and lack of information sharing between practices on EMIS/ System One where vital information could be lost.

University of Essex

17.22 There is no evidence to suggest that the University had any knowledge of Zach's relationship with Beth or the nature of it. They also appear to have very limited information about Zach's mental health, mostly it related to his ability to function academically. The University wellbeing service did make attempts to engage with Zach, but these do not appear to have been reciprocated by him. It was noted as good practice by the panel that the university night staff appeared to have knowledge of Zach's mental health and that safeguarding checks were carried out by them when he presented at the hotel on site.

17.23 It is also noted that the University work with SETDAB to ensure students are aware of support available should they experience abuse. It is unknown if Beth would have been aware of these services as she herself was not a student, but it is likely that their friends who attended the university would have known about it and would have also the undertaken active bystander initiative that the University provide as part of induction.

Pandemic

17.24 Lastly, it is important to acknowledge the unprecedented circumstances the world was experiencing in the year leading up to the tragic event January 2021. It is clear that the pandemic led to many people being isolated from both services and more informal support networks and that it had an acute impact on the deterioration in mental health of many people.

18. Recommendations

Recommendation One:

18.1 Essex Police should review its current Policy and procedure relating to the completion of DASH risk identification assessment process in cases where it is unclear who is the suspect and who is the victim and where it is also unclear that any criminal offence has taken place. The benefits of completing DASH assessments with both parties involved in order to holistically assess and understand risk should be considered.

Recommendation Two:

18.2 Essex Police should review its current working practice of recording those involved in non-crime DA incidents as either the 'Victim' or the 'Suspect'. The review should consider whether in cases where no offences are identified, the use of the Athena classification 'Involved Party' for both parties, would be more appropriate.

Recommendation Three:

18.3 Learning from this IMR should be shared and debriefed by a manager within control room staff who were involved in Call Taking, Dispatch and Supervision in relation to STORM incident EP-20201212-0100.

Recommendation Four:

18.4 The use of the THRIVE assessment model should form part of future CPD for control room Call takers and Dispatchers, to assist them in completing the assessment process, including identifying the precise nature of the Threat, Harm and Risk and enabling them to utilise THRIVE to determine the incident Header and the incident response priority grading.

Recommendation Five:

18.5 Consideration should be given to the option of developing an assessment process, to assist front line officers in assessing the dynamics of abuse, who is the primary perpetrator and the presenting risks. This would require wide consultation given that DASH is used nationally by police forces and accredited by the National Police Chiefs Council.

Recommendation Six:

18.6 A review into NHS systems and the functionality of information sharing needs to be undertaken. How to transfer medical notes between G.P. practice's to ensure crucial medical information isn't lost should be considered.

Recommendation Seven:

18.7 Primary Care should consider how to ensure that screening for domestic abuse and safety assessments are carried out as standard practice when patients present with Mental Health issues and when mental health reviews are completed as standard.

18.8 Consideration needs to be given to the transfer of medical records between incompatible systems (such as EMIS and System One).

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Appendix One

Force Procedure B1702 Domestic Abuse Investigations – Paragraph 3.1.1

3.1.1 Self Defence and Counter Allegations

Officers should avoid jumping to conclusions about which of the parties in the relationship is the victim and which the perpetrator. This applies to all types of relationships, whether heterosexual, same sex, transgender or familial (non-intimate partner). They should probe the situation and be aware that the primary aggressor may not necessarily be the person who called the police, nor was the first to use force or threatening behaviour in the current incident. They should examine whether:

- *The victim may have used justifiable force against the suspect in self-defence*
- *The suspect may be making a false counter-allegation*
- *Both parties may be exhibiting some injury and/or distress*
- *A manipulative perpetrator may be trying to draw the police into colluding with their control or coercion of the victim, for example by making a false incident report.*

Counter-allegations require police officers to evaluate each party's complaint separately and conduct immediate further investigation at the scene (or as soon as is practicable) to determine if there is a primary perpetrator.

If both parties claim to be the victim, officers should risk assess both. There may also be circumstances where the party being arrested requires a risk assessment, as in the case of a victim retaliating against an abuser. Officers should bear in mind the possibility that the relationship is a mutually abusive one.

When investigating counter-allegations, officers should note and record:

- *Body language*
- *Comparative severity of any injuries inflicted by the parties*
- *Whether either party has made threats to another party, child or another family or household member*
- *Whether either party has a history of abuse or violence*
- *Whether either party has made previous counter-allegations*
- *Whether either party acted defensively to protect him or herself or a third person from injury*
- *What any third-party* witnesses say.

See CPS Domestic Abuse Guidelines for Prosecutors, Self-defence and Counter-allegations.

Conducting a thorough investigation into the incident will help officers to determine the facts of the situation, see APP- Investigative development.