SETDAB | Southend, Essex & Thurrock Domestic Abuse Board

Domestic Homicide Review

Harlow Community Safety Partnership

Bob died February 2022

Report Author Katie Bielec

18th July 2023

Contents Page Number

Foreword

This Foreword is made up of words from all of Bob's family including his children, father, sisters, nieces, nephews, close friends, and in-laws.

Bob worked hard as a cabinet maker and took pride in his work. He was a social character, loved to socialise with a pint. He was happy go lucky and football mad, he loved Tottenham Hotspurs. As a brother he was loving, caring and full of wise words, and when he had a drink, we only heard words of love and affection, never any aggression.

Bob was an exceptionally loyal man; notably caring, warm, and kind, with an inherent desire to protect those he loved and who loved him, he was the gentlest, most loving, and loyal person. He would do anything for you, and we never felt anything other than loved and safe in his presence. He loved to laugh and share the warmth and love he had for his family and close friends.

The entire process has been extremely emotionally draining and stressful for the family starting with one of his sons having to identify his body. It has been extremely hard to have no explanation or understanding as to why Bob lost his life. Our family cannot understand why a trained and 'dedicated' nurse left Bob to die whilst she was downstairs refusing to give first aid. We have been unable to identify any emotional or real remorse from Clare.

It has also been hard to hear him be painted as an aggressive and violent drunk who would regularly harm Clare when we have only experienced a kind, gentle and loving man.

Bob will never get to meet his grandchildren, his great nieces, and nephews. A huge hole has been left in our family. Bob might be lost to us physically, but he is with us forever in spirit, we love you forever.

Preface

Harlow Community Safety Partnership, panel members and the author wish at the outset to express their deepest sympathy to the family of Bob. This review has been undertaken in order that lessons can be learnt; we appreciate the engagement from Bobs' family throughout this difficult process. The chair of the review aimed to work with the family sensitively and with compassion.

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 Bob's death in a meaningful way and address with candour the issues that it has raised.

1. Introduction

1.1 Bob was murdered by his wife Clare whom he lived with in Harlow. Due to Bob and Clare being married Harlow Community Safety Partnership (CSP) identified the case met the criteria for a Domestic Homicide Review (DHR).

1.2 This review is a statutory requirement which will examine agency responses and support provided to Bob (not his real name) and that of Clare (not her real name) prior to his murder. The report will aim to highlight positive and supportive practice, any barriers in accessing

services and any learning that can be shared to reduce the risk of such a tragedy happening again in the future.

1.3 The review considered agency contact and/or involvement with Bob and Clare between 01/01/2016 and the date of Bob's death. Agencies were also asked to consider any events outside of these dates for this review should there be any relevant information. Family and friends were also able to provide insightful information into the couple which has also been included within the report.

1.4 The review and every panel meeting have been conducted with an open mind with an aim to avoid any hindsight bias.

2. Glossary

2.1 **AAFDA –** Advocacy After Fatal Domestic Abuse, a charity supporting families who have experienced a loss due to homicide or suicide.

2.2 **Athena** - A single integrated police IT system to manage police investigations, intelligence, custody, and case file management.

2.3 **CRU** – Central Referral Unit primary purpose of identifying and managing risk to protect vulnerable people. All high-risk domestic abuse investigations must be referred to the CRU where multi agency safeguarding plans will be formed.

2.4 **CSP** – Community Safety Partnership

2.5 **CPS** – Crown Prosecution Service

2.6 **DASH RIC**[1] – The nationally accredited SafeLives Domestic Abuse, Stalking and Harassment Risk Indicator Checklist is a tool designed to provide a consistent way for practitioners who work with adult victims of domestic abuse to help identify those who are at high risk of harm and manage their risk.

2.7 **DAIT** - Domestic Abuse Intelligence Team (now known as the Assessment Team) are responsible for monitoring all new incoming domestic abuse incidents including other incidents where vulnerability is increased.

2.8 **DASO** – Domestic Abuse Specialist Officer

2.9 **DVPO** – Domestic Violence Protection Order – Temporary Protective Order granted by the courts for victims of domestic abuse where police have concerns for their safety but there are no other enforceable restrictions that can be placed on the perpetrator.

2.10 **EPUT -** Essex Partnership University NHS Trust.

[1] https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL_1.pdf?msclkid=770463f4ceac11ec8f0466908e13260a

2.11 **FCR** – Force Control Room manages the deployment of police resources[2] and record incidents reported to Essex Police utilising a command-and-control system known as STORM.

2.12 **FLO** – Family Liaison Officer with the police

2.13 **GP** – General Practitioner a medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients.

2.14 **IDVA** – Independent Domestic Violence Advocate, support for high-risk victims of domestic abuse.

2.15 **IMR** – Individual Management Review require agencies to look openly and critically at individual and organisational practice.

2.16 **MARAC** – Multi Agency Risk Assessment Conference, meeting to discuss high risk domestic abuse cases with the aim to increase safety, reduce risk and interrupt the abusive behaviour of the perpetrator.

2.17 **Operation Juno** (now known as Domestic Abuse Investigation Team) - investigators dedicated to the investigation of Domestic Abuse related crimes where the assessment of risk had been assessed as either high or medium utilising the DASH RIC.

2.18 **PNC** – Police National Computer

2.19 **SETDAB** - Southend, Essex & Thurrock Domestic Abuse Board

2.20 **SDASH** - The SDASH (Stalking DASH) is designed to support professionals identify stalking behaviour and professional judgement when considering risk, support, and intervention.

2.21 **THRIVE** – a nationally implemented risk matrix used to assess risk and determine response. Threat (who or what is the threat to?), Harm (what is the likely level of harm), Risk (what is the risk of the threat occurring), Investigative (what are the investigative needs and requirements), Vulnerability (of the person associated with the incident), Engagement (what is required).

3. Timescales

3.1 In February 2022 Harlow CSP received a Domestic Homicide Review referral from Essex Police for the murder of Bob. The decision to carry out the review was made in March 2022. In April 2022, an Independent Chair and Report Author was commissioned with the aim of completing the review by October 2022.

3.2 The Home Office Multi-Agency Statutory Guidance for Domestic Homicide Reviews 2016, paragraph 46 states that the target timescale for completion of the review of six months. Initial information was sought by SETDAB to ensure different agencies were aware of the DHR and the requirements as well as the introductory panel meeting. However, the review was not completed in six months due to the on-going criminal case which concluded in September

[2] Current FCR Priority Grading's: 1 & 2 Emergency Response (Urban arrival within 15 minutes & Rural arrival within 20 minutes), 3 Priority Response within the hour, 4 Scheduled Appointment within 48 hours, 5 Resolution without Deployment.

2022, this caused a delay with any contact with any family/friends or colleagues. Additional details requiring further exploration were also identified causing further delay. The CSP and panel were kept up to date and informed throughout the process. Panel meetings were held in June 2022, October 2022, February 2023, and June 2023.

4. Confidentiality

4.1 In line with Home Office Statutory Multi-Agency Guidance paragraph 75, to protect the identity of those involved and to comply with the Data Protection Act 1998 pseudonyms have been used which were chosen by Bob's family and agreed by the panel.

4.2 The sharing of information between agencies in relation to this review was underpinned by the Information Sharing Protocol which is in place to facilitate the exchange of personal information to comply with the requirements of Section 9 of the Domestic Violence, Crime and Victims Act 2004 to establish and coordinate a DHR.

4.3 Panel meetings were all confidential and any sharing of information to third parties were carried out with the agreement of the responsible agency's representative, the panel and chair.

4.4 The findings are restricted to authors of the reports, their managers and panel members. Once agreed by the Harlow CSP, the Home Office will be informed, and the report will be presented to the Home Office Quality Assurance Panel for final approval. Initial learning identified through the review process will be acted on immediately.

5. Terms of reference

5.1 The Domestic Homicide Review Guidance states the purpose of the review is to:
Establish the facts that led to Bob's death and whether there are any lessons to be learnt from the case about the way in which local professionals and agencies worked together to safeguard the family.

5.2 The purpose of the review is to:

- Examine the events leading up to the incident, including a chronology of the events in question.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including challenging systemic issues and making changes to policies and procedures as appropriate.
- Improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

5.3 Key Issues:

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends, and

statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

- Determine if there were any barriers Bob or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010[3] protected characteristics.
- Review agencies response, professional curiosity, interventions, care, and treatment and or support provided.
- Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards, domestic abuse and safeguarding policies, procedures and protocols and ensure adherence to national good practice.
- Determine whether workplace policies are inclusive and enable staff to raise concerns of colleagues where there is suspected domestic abuse (either as a victim or perpetrator).
- Review how organisations can empower employees to feel safe with disclosures of abuse, or concern of another whether in work or outside of the working arena.
- Review the communication between agencies, services, friends, family, and colleagues including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse for male victims.
- Is there a consistency in how agencies respond to victims of domestic abuse when both parties may present to an agency as a victim/perpetrator (possible "bi-directional abuse" and "counter-allegations"), is there any gender bias?
- Was there any impact of the Covid pandemic on those affected by or working with the family?

6. Methodology

6.1 Domestic Homicide Reviews became statutory in 2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states '*a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:*
a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death'.

6.2 The principles of the review have been followed in accordance with the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews – Revised Version – December 2016.

6.3 The panel identified which organisation would be required to provide Individual Management Reports (IMRs) after SETDAB completed a scoping exercise across the Essex area. Agencies were provided with the terms of reference and asked to review their involvement with Bob and/or Clare including interviewing any staff where appropriate. All were asked to highlight positive practice and any learning as well as any recommendations and actions.

[3] https://www.gov.uk/guidance/equality-act-2010-guidance

6.4 All IMRs were quality assured, and any recommendations and learning agreed by senior members of staff within each organisation.

6.5 In addition to the IMRs the chair was also provided with:

- Invaluable family insight into Bob's background and his relationship with Clare.
- Statements made by Bob's family for the criminal trial.
- Judge's sentencing remarks.
- Criminal court agreed facts.
- Recording of the 999-call made to Police by Clare on the night of the murder.

6.6 Various pieces of research have been used within the analysis and are referenced throughout the report.

7. Involvement of family/friends and colleagues

7.1 Bob's family were informed of the DHR by letter as well as being informed by the FLO. They were referred to Victim Support – Homicide Support Team and where they received support from an advocate. The chair remained in contact with the family and advocate throughout the entirety of the review.

7.2 After the criminal trial Clare was informed of the DHR, provided with the Home Office Statutory Guidelines, and invited to engage with the process on several occasions via the prison liaison officer, unfortunately this was declined on several occasions. No details were available to contact Clare's family however her colleagues were spoken to by the chair.

8. Contributors to the review

8.1 IMRs were provided and presented to the panel by:

- Essex Police.
- Essex Partnership University NHS Foundation Trust (EPUT).
- Hertfordshire & West Essex ICB.

8.2 The panel comprised of agencies recommended within the statutory guidance as well as agencies with specialist knowledge of male victims and domestic abuse. All panel members were required to review each IMR, provide feedback at panel meetings and support the process. An additional contributor to the review due to their involvement with Clare was her employer.

8.3 The review panel consisted of:

Agency	**Representative and role**
Independent Chair	Katie Bielec
Essex Police	Ben Pedro Anido - T/Detective Inspector, Head of Operational Development within the Strategic Vulnerability Centre Jules Bottazzi - Head of Strategic Vulnerability Centre DS Scott Kingsnorth - TSA DI | T/Head of Operational Development, Crime and Public Protection Command

	DI Lydia George – Senior Investigating Officer (SIO)
Hertfordshire & West Essex Integrated Care Board (ICB)	Beaulah Chizimba - Interim Designated Nurse Safeguarding Adults Zivai Muyengwa - Designated Nurse Safeguarding Adults
Harlow Community Safety Partnership	Christine Howard - Strategic Manager for Community Safety, Youth and Engagement / Designated Safeguarding Officer
SETDAB Team	Emma Tulip-Betts – Specialist Wellbeing & Public Health Officer
Essex Partnership University Foundation Trust (EPUT)	Nicole Rich - Director West Essex Community Physical and Mental Health Services Tendayi Musundire - Associate Director for Safeguarding
Adult Social Care – Essex Council	Elaine Oxley - Director of ASC Safeguarding and Quality Assurance
Next Chapter (Domestic Abuse Service)	Nicola Taylor – Service Manager
Male Victim Specialist Service - Safer Places	Gemma Toynton - Independent Domestic Violence Advocate (IDVA)
Open Road – Substance Misuse	Joni Thompson - Clinical & Business Development Director
Alpha Vesta	Lucy Whittaker- Chief Executive Officer

9. Author of the Overview Report

9.1 Katie Bielec is an independent domestic abuse consultant providing support and training across England. She chairs MARAC, Multi Agency Risk Management Meetings, and stalking clinics. She is an associate trainer for Safelives, Rockpool, The Hampton Trust, a guest lecturer at Bournemouth University and is an accredited trainer delivering Coercive Controlling Behaviour and Stalking.

9.2 Katie was previously a Metropolitan police officer working in a variety of roles, she is a qualified IDVA, IDVA manager, ISVA[4] Manager and managed domestic abuse services for 11 years.

9.3 Katie is an accredited chair with AAFDA and SILP[5], has completed the Home Office Domestic Homicide Review Training, is a member for AAFDA DHR Network, Standing Together Against Domestic Abuse Coordinated Community Response and The Employers Initiative on Domestic Abuse.

9.4 Katie is not associated in any way to any agency who have provided information for the review or had any personal or professional involvement with Bob, Clare, or their families.

10. Parallel Reviews

10.1 A criminal trial was held in August 2022 where Clare was found guilty of murder and sentenced to life in prison. There were no other reviews being conducted at the time of this review.

[4] ISVA – Independent Sexual Violence Advocate, support for victims of sexual violence/abuse.
[5] https://www.reviewconsulting.co.uk/silp-reviews/

11. Equality and Diversity

11.1 The chair and panel members considered whether any protected characteristics were relevant within the review. Bob was a 57-year-old white British male; Clare is a white British female and was 51 years old at the time of the murder. There was no information to suggest Bob had a disability. Clare had been diagnosed with fibromyalgia, and at times had been signed off from work due to tiredness, however, it does not appear to have impacted her performance at work. No information has been provided to believe either person had religious beliefs.

11.2 Bob's sex was taken into consideration for this DHR as a risk factor due to domestic abuse and domestic homicides of men with female perpetrators being significantly fewer than female victims and male perpetrators. A recent review of DHRs[6] found 20% of victims were male with female perpetrators equating to 17%. Therefore, the panel felt it important to understand if Bob faced barriers in identifying the abuse and seeking support as well as agency responses to both Bob and Clare.

12. Dissemination

12.1 Bob's family and all agencies involved in the review are aware of the Overview Report and an Executive Summary will be published on the SETDAB website[7] and shared with the Safer Harlow Partnership Board, Essex Police Fire & Crime Commissioner and the Domestic Abuse Commissioner once agreed by the Home Office. The action plan has already been disseminated with all relevant agencies to ensure immediate action and learning could be taken forward. All other reports and IMRs will remain confidential and will not be shared.

12.2 Harlow CSP and the chair will work with the family and other partners with regards to any public/press interest.

13. Homicide the facts

13.1 The evening prior to Bob's death, he had been to a public house where he had met friends and drunk alcohol. Clare had been at work (as a community nurse) with a fellow colleague and student shadowing her, her shift finished at approximately 23:00 hours.

13.2 When Bob returned home, Clare was already at the property and was using the computer which was situated downstairs. The couple drank alcohol together and during this time Clare alleged Bob called her '*worthless and/or useless*'. At about midnight Clare supported Bob upstairs, helped him to get into his pyjamas and into bed. Clare went back downstairs, continued to drink red wine, and search the internet whilst Bob went to sleep.

13.3 Shortly after 02:00 hours the following morning Clare went to the kitchen, selected a knife, went to the bedroom (where Bob remained asleep), and stabbed him twice in the stomach.

13.4 Clare called 999 requesting an ambulance and the police, she refused to provide Bob with any help whilst on the phone to the call handler who repeatedly asked her to stem the blood flow.

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[6] https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews#introduction

[7] https://setdab.org/

13.5 Paramedics attended the address; Bob was taken to hospital where he underwent surgery but later died.

13.6 Toxicology reports found Clare had 138 milligrams and Bob had 152 milligrams of alcohol per 100 millilitres in their blood at the time of the murder (80 milligrams of alcohol per 100 millilitres is the legal limit to drive a car).

14. Family, relationship background and colleagues

14.1 Bob was born in Enfield in 1964. His mother passed away in 2012, his father was 89 years old (at the time of Bob's death and has since become quite frail and withdrawn as he tries to come to terms with Bob's murder) and he had two siblings, an elder and younger sister. The family moved to Harlow in the 1970s and have remained there ever since. He met his ex-wife Joyce (not her real name), and they had 3 children together (all are now adults). After the marriage ended the children remained living with Joyce, however, Bob saw them on a regular basis.

14.2 In 2004 Bob met Clare at a local social club and they married in 2007. Clare had never been married and had no children. According to family members, Clare had wanted to have children, but Bob did not due to having his 3 children with Joyce.

14.3 Both Clare's parents have passed away, her father died recently which appears to have impacted on her emotional wellbeing. She also has two brothers, one in Wales and the other abroad of which she has limited contact with.

14.4 Bob would attend the local public house with his father every Friday to play darts and his father would go the couple's home every Sunday for lunch. Bob was in contact with his sisters however, this was limited due to Clare's behaviour whilst intoxicated and her apparent jealousy.

14.5 Bob's youngest sons first memory of Clare being abusive to his Father (he was of primary school age), was at the couple's home, Bob had made dinner, Clare came in and started shouting at Bob for leaving the hot water heater on. She then grabbed the child's head (a hand either side of his face) and started shouting, he cannot recall exactly what was said other than something similar to *"do you understand!"*. He recalled he was upset as Clare had not allowed him to call his mother and remembered feeling 'shaky' after the incident.

14.6 After this incident, the children did not see Bob or Clare for a period as their mother had wanted to keep them away from the situation.

14.7 When Bobs' youngest son was about the age of 12 or 13, there was an incident at the social club when Clare hit Bob around the head with a pool cue. He recalls that she was drunk, and her behaviour would switch from either very 'lovey-dovey' or 'out-of-control.'

14.8 When Bob's son was 14 years old recalled he was upstairs at the couple's home, and he heard a crash from downstairs. When he went downstairs, he saw Bob had nearly gone through a glass table after Clare had pushed him. He was collected by his grandfather and did not stay there again.

14.9 Bobs' relationship with his children became limited in 2017 due to Clare's behaviour, however later that year Bob resumed contact with his youngest son via the phone.

14.10 In 2018 Bob's son saw the couple in a local pub, he describes Bob as being pleased to see him, but he felt Clare less so. During that year he and his then partner went to see his father and Clare at their home. Whilst there, Bob had half a glass of wine, Clare a bottle of wine and they drank tea. Clare became very drunk and made comments about the son's appearance making him feel uncomfortable.

14.11 During 2020 and 2021, there was text and phone contact between father and son, but they were unable to see each other due to COVID. Bob's son recalls his father had become "a bit of a recluse" throughout that period and felt he had been suffering in silence. After restrictions lifted, they started to see each other, even though this was not frequent they remained in regular contact via the phone. Bobs' youngest son describes his dad had become his best mate and the reconnection meant everything to him. They would spend cherished time together at the pub and at the end of the night Bob would give him a cuddle telling him he loved him.

14.12 The son's perception of Clare was that she had a hold over Bob, he never saw his father with any type of bruising or injury and believes that due to being the youngest, Bob kept him away from seeing these. He believes his father would never have spoken about his relationship with Clare to him or any other person.

14.13 Bob's younger sister recalls Clare liked to drink alcohol and that she had been drunk on most occasions she had seen her. When she had not consumed alcohol, she was quiet, reserved and did not mix with other members of the family. However, when she had been drinking, she 'became a different person', describing behaviours switching from '*gushy*' to '*acting as if she did not know you'*.

14.14 The first time Bobs' sister recalls Clare being aggressive or acting completely out of character was just after Christmas in 2021 at a family gathering. They had been to the pub before meeting the family, when they arrived, they had brought wine and beer with them, both had not eaten but were in good spirits.

14.15 Clare spoke to Bob's brother-in-law and told him she felt jealous of his relationship with his stepchildren and how she wished she had the same with Bob's children. She continued to drink wine stating she had been drinking continuously since her cat had died a couple of months before. By this point she was struggling to keep her wine in the glass and appeared very drunk. At some point during the evening Clare went outside in the rain without footwear and urinated herself, when she returned inside the house her behaviour got worse and she struggled to stand.

14.16 Bob told Clare to sort herself out and told his sister they were leaving, when they tried to move Clare, she fell off the chair and onto the floor. The taxi refused to take Clare due to her being too drunk. She told Bob they should not have gone there that evening at which point Bob's brother-in-law said to her *"come on, don't be silly."* At that point Clare asked who he was and acted as if she did not know him. Bobs' sister responded with "*don't be silly*," Clare then went nose to nose with her and said ''*I am not silly, who the fuck are you?! You are*

nothing to me, you are not my family, and you are not my dad" (pointing to Bob's father). At this stage Bob's elderly Father took the couple home.

14.17 The family do not believe Bob would have identified himself as a victim of domestic abuse, although he recognised his relationship was not healthy and at times 'toxic.' They recall Bob as a dedicated husband, she was his priority, he was committed and loyal to her. They are clear they do not believe he would have sought support regarding the abuse. They describe him as very private and do not believe even if they or friends had approached him, he would have made any disclosures.

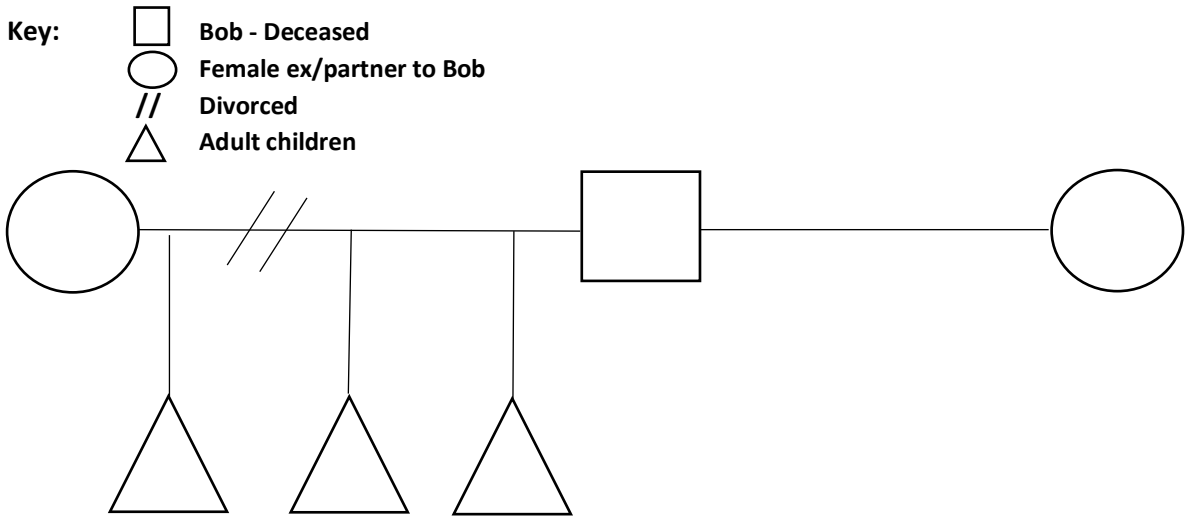
14.18 Bob's family believe he would still be alive today if professionals had responded to Clare appropriately, especially those how have a duty of care to the public. They believe he was failed by too many professionals along his life's journey.

14.19 Bob was a carpenter working for a local company (although he identified to agencies as being self-employed) and Clare a community nurse in the Harlow area from 2006 until her conviction. Unfortunately, the review was unable to speak to any of Bob's colleagues.

14.20 Clare's colleagues described her as a kind, compassionate and patient nurse who loved her job and worked very hard for her patients. She was proud of her work and '*wanted to a happy life'*, everyone went to her for advice or support, always working at a fast pace, and they were completely shocked and devastated by her actions. Clare also worked as a bank nurse for a private health care service but stopped when she was promoted within the NHS.

14.21 Clare did not socialise or have contact with her colleagues outside of work and would only attend organised 'work nights out', during these occasions when she had been drinking, her behaviour had not raised any concerns.

15. Genogram



16. Chronology

16.1 Although a timeframe of 2016 – 2022 was set within the terms of reference, there was contact with Bob, Clare and Joyce where domestic abuse was identified prior to these dates and

therefore relevant for the review. Due to the dates of the records information is limited, however, the following has been established:

16.2 In 2002 a domestic abuse incident was reported to police by Joyce regarding Bob. Bob had caused her alarm and distress and criminal damage to her property, at the time of the offence Bob was intoxicated, he pleaded guilty at court.

16.3 In January 2004 police were called to a verbal disagreement between Bob and Clare, both were under the influence of alcohol. Bob had an injury to his knuckle but did not give officers any information regarding how he sustained the injury. No complaints were made, and no action was taken.

16.4 In December 2004 whilst out at a social event police were called after Clare had punched Bob in the mouth causing cuts and swelling. Bob had attempted to restrain Clare which resulted in her biting him on the calf causing bruising, this incident occurred in front of Bob's children. No further action was taken by Police on this occasion.

16.5 Between 2008 and 2018 Clare's colleagues were aware of the domestic abuse within the relationship and describe how Clare would come to work with bruises, black eyes, bruising around her wrists, broken ribs and was at times very distressed due to the environment at home.

16.6 In May 2010 Essex Police received a 999 call from Clare stating that she had been assaulted by Bob at their home address. Officers attended, arrested Bob and he was taken into custody. When entering custody, he informed custody staff that he had drunk alcohol (it is unclear how much). Officers also noted that Clare was intoxicated at the time of them first attending and she was unable to provide a statement. Arrangements were made for her to have her statement taken later that morning along with photographs of her injuries. Clare was later seen by officers, a statement obtained, and a crime report completed. In addition to the alleged assault the night before, she also claimed she had been assaulted in February 2010 by Bob stating he had pushed her over at home causing her to fall against a coffee table cracking a rib. A DASH RIC was completed, and she was assessed as high-risk, it is not known if the case was referred to MARAC.

16.7 Bob was interviewed, charged with assault (battery) and bailed with conditions whilst he awaited trial.

16.8 A Domestic Abuse Liaison Officer (DALO) was in contact with Clare who informed them that she was seeking advice from a solicitor within the week to seek a divorce. She declined all other support but expressed anxiety about giving evidence at court. The officer provided reassurance and offered to call and speak closer to the court date.

16.9 In August 2010 Bob appeared at court, the CPS offered no evidence, and the case was dismissed (the reasons for this was not recorded).

16.10 During the intervening period of 6 years (2010 and 2016) there were no recorded contacts between Essex Police, Bob, his family or friends or Clare.

16.11 In January 2016 Clare presented at her GP surgery on 3 occasions, on each occasion she was seen by a different GP. Within these appointments she disclosed pain in her back, rib cage, general pain on both sides of the chest wall, pain in her right leg and left arm as well as feeling tired. She also informed the GP she was a heavy cigarette smoker, and they identified her cortisol levels were high. She diagnosed with fibromyalgia and issued a 'not fit for work' note.

16.12 In the early hours of June 2016 Essex Police FCR received a non-emergency telephone call from Clare stating that she had been involved in a domestic abuse incident with her partner (at the time of the call she did not disclose who her partner was). As a result, she had left her home address and wanted to go somewhere safe for the night.

16.13 An incident was created and graded as a Priority 1(Urban Emergency) and tagged for the attention of the DAIT. The officer located Clare and took her to Harlow Police Station as a place of safety and obtained an account from her.

16.14 In the interim DAIT updated the incident, they undertook initial checks of police databases and recorded 'no trace' of Clare on Athena and that PNC showed one historical arrest. Wider intelligence research indicated that her partner may be Bob, PNC showed he had warning markers for violence and alcohol.

16.15 Clare informed officers that the day before she had met a close male friend who she had known for twenty years and would meet once a year. She stated she had no other close family or friends. After she had returned home, she met Bob at a local Harlow public house where they had several drinks before returning home. Once home Bob had begun to argue with her due to being angry that she had met her male friend. Bob had become aggressive slamming a cupboard door causing a glass to smash. He had then grabbed her to the back of the head and with the other hand had hit her on the forehead with a glass ashtray causing an injury (lump to forehead). She had left the home fearful of what may happen next.

16.16 The allegation was 'crimed' and a DASH RIC completed, during the assessment Clare described an assault where Bob had used a piece of wood and threatened to kill her (this had taken place 6-7 years earlier). Additionally, she spoke of historical strangulation, jealousy, him not wanting her to see friends and feeling isolated. As a result of the information Clare was assessed as high-risk, Bob was arrested on the same day at the home address for the offence of Actual Bodily Harm (ABH).

16.17 The investigation handed over to specialist officers from Operation Juno. Bob was interviewed under caution and gave an account in which he stated that an argument had occurred at the home address with Clare and that he had slammed a door causing a glass to break. He had then been struck on the chin with an ashtray by Clare (when arrested and entering custody it was noted that he had a cut to his chin) and he had reacted by holding the back of Clare's head and held an ashtray hard against her forehead asking her, *"how do you like it?".* After he let her go, Clare threw a glass at him and then left the home address.

16.18 Bob accepted that what he had done was wrong and that he should have walked away but stated he had reacted Clare had assaulted him. Following the interview the case officer spoke to Clare and she confirmed that she had in fact hit Bob first with an ashtray causing the injury to his chin.

16.19 Clare was advised that a file would be submitted to the Crown Prosecution Service (CPS) and that Bob would remain in custody whilst the advice was sought. She declined to provide a statement and stated that she would not support a prosecution, nor would she attend court.

16.20 Whilst Bob was in custody, the CPS determined that the threshold test had not been met and no further action was taken in relation to criminal charges. However, given the allegation and the assessment of risk the Superintendent authorised the issue of a DVPN which was served on Bob prior to his release.

16.21 On the day of the allegation and with the information provided by Clare, Essex Police made a referral for IDVA support[8] and MARAC. The DASO tried to contact Clare by phone however she did not answer the calls, a discreet message was left on her answer phone for her to contact them. As Clare could not be contacted a skeletal safety plan was put in place by the DASO including flagging the home address and her phone and to treat all subsequent calls as urgent.

16.22 Bob appeared at court two days after the initial allegation where a DVPO was granted for 14 days. Police contacted Clare on the day of the DVPO, but she told the officer she could not speak and hung up, the investigation was filed.

16.23 The couple were discussed at the MARAC at the end of June 2016, agencies recorded as present were Children's Health, Children's Social Care and Police. Recorded on the MARAC Action Plan the only information shared was by the Police, the records indicate no other agencies were involved with either person. An IDVA update was not provided at the meeting, so engagement was unknown. There is no record of Clare being aware of the MARAC, being contacted after the MARAC or to provide her an update on any actions.

16.24 One colleague recalled that Clare had told them police were involved due to the violence, but she loved Bob and could not go through with taking him to court. There had been discussions of her leaving, but she had stated she did not want to leave Bob, her home, or her cats so they felt it was never a realistic option for her.

16.25 Another colleague explained that although Clare had never explicitly told her that Bob had caused the injuries and stated they were due to falls or her bumping into things, there was an awareness and belief that Bob was hurting her amongst the team.

16.26 It had become the 'norm' for Clare to come in with injuries, a colleague had raised her concern with a manager and there was an assumption management were supporting her.

16.27 In June 2017 Clare saw the Physiotherapy assessment and treatment team due to back pain (reason provided was due to her work as a nurse) and was discharged in August 2017.

16.28 Clare was promoted by her employer to a Band 6 community nurse in January 2018.

16.29 Clare experienced a sudden bereavement in May 2018, she saw her GP who provided a 'not fit for work note' due to stress and was off work for 20 days.

[8] The IDVA provider at the time informed the panel their Retention Policy had recently changed from 2 years to 5 years – and they had no information on system in relation to either party.

16.30 The GP contacted Clare by telephone regarding medication for her back pain in November 2018, she was offered a face-to-face appointment several days later which she did not attend. She attended the re-arranged appointment where medication was reviewed, no details of the cause of back pain was documented. She then attended A&E regarding chest pains, palpitations, and muscular pains (detail of the cause or treatment provided was unavailable).

16.31 Bob's GP referred him for an orthopaedic appointment due to problems with neck pain after an incident carrying a large board in January 2019. An appointment was made for an Orthopaedic clinic in February 2019.

16.32 In February 2019 Clare saw her GP with rib pain after a fall on the stairs, medication was requested (it is not documented what caused the fall or if medication was provided).

16.33 Clare disclosed to the GP in April 2019 that she had fallen on the stairs 3 weeks previously, had fallen headfirst and sustained facial bruising (no information is recorded as to the cause of the fall and whether this was the same fall noted in February or another fall after this incident). She was advised against the pain relief medication she was prescribed and to exercise, use heat and self-refer for physiotherapy, she was diagnosed with neck pain. There were no concerns raised at her workplace regarding any bruising and at no time was any time taken off after this fall.

16.34 In June 2019 Clare had 2 days of sickness from work citing anxiety/stress/depression.

16.35 The GP received a letter from Healthy Minds (a psychological service) regarding Clare in July for insomnia and depressive disorder. She was advised to start Mirtazapine with a 6–8-week review (there is no indication that this happened).

16.36 Clare attended the GP on two occasions in December 2019 and was provided a 'not fit for work' note citing stress, her absence report at work cites anxiety/stress/depression/other psychiatric illnesses, it was not recorded the cause of the stress.

16.37 Whilst off work Clare was referred to Occupational Health in January 2020 by her employer, was provided with the organisations Employee Assistance Programme (EAP) contact details and advised to see her GP as soon as possible for support. A further Occupational Health telephone review was arranged for February 2020, Clare did not contact the EAP as advised.

16.38 Clare kept her employer updated with regards to the Healthy Minds follow up and GP advice, she was off work for a total of 118 days and returned with a recommended 3-week phased return by Occupational Health.

16.39 The United Kingdom experienced the COVID pandemic from March 2020 with the population subjected to a nationwide lockdown between 23rd March 2020 – 21st June 2020, with a gradual easing of restrictions throughout the summer of 2020.

16.40 Clare's colleagues recall their concerns and seeing her injuries up until COVID, however after restrictions lifted no further concerns were raised with regards to physical assaults.

16.41 Due to Bob's neck pain not improving with physiotherapy a further referral was made to Stella Healthcare in July 2020.

16.42 In September 2020 Bob attended A&E (alone) after he reported falling and slipping down the stairs six weeks previously. He had a hip examination and X-ray of his pelvis, and the GP was notified of this attendance. There is no record of how Bob had slipped and fallen down the stairs.

16.43 In October 2020 Bob sought support due to 'hip power' and his knee buckling/giving way, this was attributed to potentially a result of heavy lifting. During this month Clare reported to her GP as being stable on Citalopram.

16.44 There were two further lockdowns in November 2020 and January 2021 with phased 'easing of restrictions' up until June 2021.

16.45 In February 2021 Clare reported she had twisted her knee twice but did not want to bother anyone during COVID and bought support from Boots. She reported to have fallen on her knee after she had missed a step, resulting in her knee swelling.

16.46 Clare was referred to Occupational Health in March 2021 after an MRI scan identified arthritic changes and damage to Anterior Cruciate Ligament with advice to wear knee brace and take anti-inflammatory analgesia. Clare was unable to bend down low and had difficulty getting up, it was recommended that when she returned to work there would be restrictions for 3 months with no heavy lifting/ no work/treatment of legs, to drive locally if fit to drive and if not fit to drive to return to office type duties.

16.47 At the end of March 2021 Bob attended a health check, during his appointment there was a discussion regarding his alcohol intake, he stated he had one or two units when drinking. Bob told disclosed he drank eight units or more on one occasion on a weekly basis. When asked if he or anyone had been injured because of his drinking he said 'no.' Bob shared that no relative, friend or professional had been worried about his drinking. He identified himself as a smoker, however, did not want to quit.

16.48 The GP issued a 'not fit for work' note (no details provided with regards to the reason) to Clare in April and May 2021. It was recorded within her work Absence Report this was for 'Other musculoskeletal problems,' she was off work for a total of 106 days.

16.49 In June 2021 Clare had blood tests in relation to menopausal systems including hot flushes, tiredness, forgetfulness, weight gain, anxiety, body aches and missed periods. Her blood tests confirmed her hormone levels were consistent with menopause.

16.50 At the end of the summer in 2021 Clare presented with a dog bite that had happened over the weekend, she had treated herself and no action was taken.

16.51 Two weeks prior to Bob's death Clare sent several text messages to a colleague (on a work phone), one stated she was an alcoholic and she wanted to take her own life. Her colleague offered to collect her, but she declined. Clare's colleague raised concerns with their manager as they were concerned for Clare's welfare and her patients. The manager sought advice for

Clare's mental health via the organisations 'Hear for You' advice and support. They advised her to contact the Employment Assistance Programme (EAP) or to contact the crisis team on 111. This advice was provided, however, there is no record to evidence the concerns of her alcohol use were raised or discussed with Clare.

16.52 A couple of days after Clare's colleague raised these concerns, they contacted the 'Staff Engagement Champion' for advice, they were advised to speak to the 'Freedom to Speak Service' who recommended Clare should attend A&E if she was concerned for her welfare.

16.53 Clare's colleague told her the action they had taken and their reasons, they report she appeared to understand, and they remained in contact, however, they were unable to answer further messages due to them being on holiday. One of these messages Clare sent stated that in the previous three years Clare had drunk alcohol every day apart from eleven days and that Bob was also drinking alcohol with her.

16.54 Police found between January 2022 and the night of the murder multiple internet searches had taken place on the computer within the home (Clare was the main user of the computer as Bob did not use IT equipment), the searches included:

- Domestic Abuse and Suicide.
- Sodium thiopental (a rapid onset short acting barbiturate general anaesthetic).
- Murders and capital punishment.
- Death row inmates.
- Fatal car crashes.
- Fatal car crashes where drivers were drunk under the influence.
- Deaths caught on camera/tape.
- Police shootings.
- Interviews with serial killers before execution.
- Alcohol intoxication.
- Mothers killing children.

17. Analysis

17.1 Community response and identifying abuse.

17.1.1 Reports from the family have indicated there were incidents of violence in the home and in public. Due to the abuse and Clare's jealousy of Bob's relationship with his children it resulted in him becoming isolated from them. At no stage did Bob tell his friends or family of the abuse other than to the police in 2010 and 2016. The family were clear that Bob took his marriage vows and his commitment to his wife seriously and do not believe he would have disclosed to them or any other person and would not have ended the relationship.

17.1.2 Elizabeth Bates (2019) research "*No one would ever believe me", an exploration of the impact of intimate partner violence victimization on men"*[9]; highlighted a barrier for male victims seeking help was due to them having protective or chivalrous attitude towards their partner (Entilli & Cipolleta, 2016).

[9] http://insight.cumbria.ac.uk/id/eprint/4367/

17.1.3 None of the behaviours appear to have been recognised as abusive by Bob, those closest to him and the wider community. It highlights that not all abuse is easily identifiable or considered abusive in the moment. Bob's family do not believe he would have seen himself as a victim of domestic abuse and those around him did not specifically identify him as a victim of domestic abuse. This may have been due to lack of awareness but also societal perception of how a 'man should behave' and the barriers that can create for male victims seeking support. Elizabeth Bates identified; '*The message constructed for men and their gender roles are to be emotionally self-reliant, stoic, and powerful, which likely means avoiding behaviour that makes them seem to not live up to these expectations. This can lead to men avoiding the problem (Tsui, 2014) and feeling shame and embarrassment (Hogan, 2016). There is a need to try and change this dominant narrative about gender roles in order to start to address men's barriers to help-seeking.* This social construct regarding 'how men should be' may not have only created a barrier for Bob but also his family and those around him in seeking advice and support.

17.1.4 Raising public awareness is identified in The Tackling Domestic Abuse Plan 2022[10] Problem Four – *'Identifying more domestic abuse cases. Currently there are gaps in public awareness of what constitutes domestic abuse, which hinders identification of cases. Increasing the ability of professionals to identify and respond to domestic abuse cases, particularly those more likely to regularly encounter them, should also contribute to identification of more cases. And the system needs to provide more opportunities for victims and survivors to disclose abuse by addressing the reasons why they do not do this. These include not knowing if or where support existed or how to access it.'* It is therefore important raising awareness not only of the domestic abuse behaviours but how these may present to different members of our society and the impact it has on victims is incorporated within any domestic abuse strategy and campaign.

17.1.5 The language used should be carefully considered with any campaign especially when aiming messages at men. Elizabeth Bates found that men struggle with the label 'victim' and can at times perceive public awareness campaigns around domestic abuse initially for women and not men. As previously noted, there is an element of shame, embarrassment and de-masculinity for men who are considering seeking support. Across the country there are excellent campaigns providing the opportunity for safe spaces for women under the VAWG Strategy[11] such as the Enough Campaign[12] Ask Angela[13] and Ask Ani[14], it would also be beneficial to work with male support services to develop a similar campaign for men. The introduction of International Men's Day has started this shift however, further campaigns should provide focus on communities where men frequent, providing increased confidence in how to talk about abuse, feelings and how to access support. When the family were asked if they knew of domestic abuse services for men, they were unable to name any either locally or nationally.

17.1.6 The SETDAB Domestic Abuse Strategy 2020 – 2025 has identified Campaigns as part of its outcome:

[10] https://www.gov.uk/government/publications/tackling-domestic-abuse-plan
[11] https://www.gov.uk/government/publications/tackling-violence-against-women-and-girls-strategy
[12] https://enough.campaign.gov.uk/
[13] https://www.nationalpubwatch.org.uk/news/ask-for-angela-if-you-are-feeling-unsafe/
[14] https://www.gov.uk/guidance/ask-for-ani-domestic-abuse-codeword-information-for-pharmacies

Outcome 5: Communities, professionals, and employers can recognise domestic abuse at the earliest opportunity and have the confidence to take action.
Aim: Raise level of awareness and confidence in all areas of the community to enable everyone to recognise and respond appropriately.
Measure: Increase referrals to support services, visit to SETDAB website, professionals being confident in responding, number of subscriptions to the SETDAB newsletter and professionals completing available e-learning.

17.1.7 This is a proactive strategy in engaging with the community and to promote and have clear plans for campaigns there is a Campaigns Strategy 2020 – 2025 which highlights victim maps and insight, themes, clear support pathways and how they will aim to educate and disrupt behaviour. The strategy and campaigns are aimed at both the community and professionals which will aim to continue to raise awareness around domestic abuse especially regarding those who are harder to reach.

17.1.8 It is positive SETDAB have these strategies in place however when reviewed it will be essential all members of the community are invited to any focus or consultation groups as there appears to still be members of society who do not recognise domestic abuse and would not know where to seek support.

17.1.9 As part of reaching out to the community domestic abuse services who provide support to both women and men should be able to offer male and female workers, adapt their support according to the needs of their clients and understand the differences in the trauma experienced. Male responses may be different to women; therefore, services cannot be 'generic,' and they need to be able to offer tailor made interventions, providing victim/survivors choice and agency over their support and future.

17.1.10 Although not evident within the agency reports, the family and Clare's colleagues raised possible financial concerns. During the pandemic Bob was on furlough and Clare was off from work for lengthy periods of time and this may have contributed to the couples' financial pressures. Clare used to work additional hours with colleagues raising concerns with how many hours she worked. However, she gave the impression she had to pay for all the bills and any work for the house with Bob not contributing (this has not been confirmed with any evidence from financial records). Clare's colleagues also recall when she had to have time off work to care for Bob when he had hurt his back. All of which may have impacted on any possible financial strain within the relationship. During COVID Bob would have been receiving furlough payments, shortly after the pandemic Bob asked his father for money, it is unknown the amount, what it was for or whether Clare was aware of this, however, it again raises the possibility the couple were struggling financially.

17.1.11 It is unclear whether there was economic abuse within this relationship, but it cannot be ruled out. Economic Abuse was introduced into the Domestic Abuse Act 2021 due to it being identified as the second most common form of abuse within domestic homicides[15] after coercive controlling behaviour. The charity Surviving Economic Abuse[16] highlights economic abuse is a form of coercive and controlling behaviour and one of the most likely forms of abuse

[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1149612/Annex_A_DHRs_Review_Report_2020-2021.pdf
[16] https://survivingeconomicabuse.org/what-we-do/research-and-evidence/

a victim/survivor may be subjected to and therefore it may have been a factor with Bob and Clare.

17.1.12 The charity Mind[17] found that those with financial difficulties were impacted not only with their mental health, but there was also the possibility of increased use of substances and greater risk of isolation. We know that Bob and Clare drank and smoked heavily, had few friends with limited contact with family members. Bob was a "proud man with traditional views" regarding his relationship therefore with these additional stressors in his life this impacted on his health and wellbeing and may have been a further barrier in seeking support.

17.1.13 Alcohol was an identified reoccurring factor within the relationship and appeared to have been part of the couple's day to day lives. With the increased use of alcohol and dependence there is a risk of 'alcohol harm' which can not only be experienced by drinkers but by those around them including families, friends, colleagues, and strangers. There is a strong relationship between alcohol and domestic abuse. Whilst alcohol should not be used as an excuse for those who perpetrate abuse, neither should its influence be ignored.

17.1.14 Bob's family were concerned with Clare's behaviour when she had drunk alcohol to an excess, when Clare was '*in drink*' she appears to have increased her risk-taking and was unable to make safe and rational decisions. Her behaviour at times was violent and abusive not only to Bob but also to other family members and ultimately in her taking Bob's life. Drinking was a significant part of their social life and seems to have been 'accepted' in how they behaved around each other.

17.1.15 The Institute of Alcohol Studies[18] highlight that whilst the majority of reported domestic abuse incidents involve male to female abuse, less is known about incidents where men are the victims of female abuse, or where both partners act as perpetrators. However, research suggests alcohol plays a significant part in these scenarios as well, particularly where both partners engage in violence. Women's use of violence has at times found to be defensive, however, studies have found alcohol to have a small but significant effect on female to male violence. They state that neither of these facts is surprising, given alcohol is associated with increased aggression.

17.1.16 Cases of dual perpetrator domestic abuse have found to include the highest number where both partners were alcoholics or heavy drinkers, with alcohol present in 88% of such cases, significantly higher than the sole domestic violence perpetrators in the sample (63%)[19].

17.1.17 One study found that, even though both partners engaged in alcohol or domestic abuse, a far greater number of the total cases of domestic abuse were attributable to men, and men were more likely to be recorded as using alcohol – 87% and 66% respectively compared to 68% and 44% of women.

17.1.18 The Institute also highlighted that typically between 25% and 50% of those who perpetrate domestic abuse had been drinking at the time of assault. Although in some studies the figure is as high as 73%. Cases involving severe violence are twice as likely as others to include

[17] https://www.mind.org.uk/information-support/tips-for-everyday-living/money-and-mental-health/the-link-between-money-and-mental-health/
[18] https://www.ias.org.uk/uploads/IAS%20report%20Alcohol%20domestic%20abuse%20and%20sexual%20assault.pdf
[19] Hester. M. (2009), 'Who Does What to Whom? Gender and Domestic Violence Perpetrators', p. 15

alcohol. Where alcohol is involved, evidence suggests that it is not the root cause, but rather a compounding factor, sometimes to a significant extent such as with Bob and Clare.

17.1.19 There are already awareness campaigns for the impact of excessive drinking with regards to it impacting your physical and mental health. It would be beneficial to raise awareness of how the use of alcohol can be used to mask a behaviour or be used as a coping strategy. This may then enable people to understand the complexities and offer support and advice to those they have concerns for.

17.1.20 Domestic Abuse is a complex crime which has many layers of abuse, manipulation, societal perceptions, and additional factors. Professionals require and expect training to be able to identify and respond to domestic abuse, however; no such training is required or expected to be delivered or attended within communities. Yet practitioners and the wider society may assume victims, family and/or friends to be able to identify and respond to the abuse. This assumption can be dangerous and unrealistic and therefore support for communities needs to be developed, grown, and sustained to create confidence in approaching victims and those using harmful behaviours and enabling them to provide details of support available.

17.2 Essex Police

17.2.1 Essex Police had limited involvement with both Bob and Clare during the period under review having only dealt with them once in 2016 and then the murder nearly six years later.

17.2.2 Bob was recorded and dealt with as the perpetrator by police on every occasion, but when he made the disclosure of the assault by Clare an Athena Investigation (Crime) should have been created with Clare recorded as the suspect, regardless of whether he wished to actively pursue a complaint or not.

17.2.3 National guidelines were and remain clear on when crimes should be recorded and the practice to be adopted when dealing with counter allegations during assault investigations, this is with the aim to deliver crime recording consistency within England and Wales[20].

17.2.4 It would have also been expected after the assault being disclosed a DASH RIC would have been completed with Bob. These were missed opportunities for officers to evaluate the risk to Bob, make any appropriate safeguarding referrals and offer him information regarding support. This may have enabled him the opportunity to make further disclosures about his relationship. Unfortunately, due to this not being completed Bob was not given the same or similar opportunities, interventions, or support as with Clare. The review has been unable to determine if the failure to record the counter allegation made by Bob was due to gender bias. However, based upon the records available, Bob was consistently seen (by those responsible for the investigation and its supervision) as the perpetrator, was dealt with as such and therefore treated differently to Clare.

[20] **Recording Practice: Counter Allegations of Assault, National Crime Recording Standards**
When assaults are alleged to have taken place, these should be recorded in accordance with the NCRS. Very often, however, offenders claim that they were acting in self-defence and make counter allegations of assault. Great care should be taken before routinely recording such allegations as crime. For example, when the offender in a case of GBH or ABH makes a counter allegation of assault this should only be recorded as such if on the balance of probability, the offence took place (in accordance with the NCRS). The absence of any evidence such as personal injury or independent witnesses may show that the allegation is false, and care should be taken before recording as a crime. Each case should be treated on its own merits. It should be noted that any decision not to record such counter allegations as a crime should be recorded for disclosure purposes.

17.2.5 Clare admitted assaulting Bob but due to him not wanting to make a formal complaint or provide a statement and she was not arrested. With this admission it was an opportunity to have explored with them both what was happening within the relationship. Michael Johnson typologies[21] explains a 'Violent Resistor' is the primary victim in an abusive relationship who uses violence to keep themselves safe or are no longer being able to cope with the abuse within the relationship. Although we do not ask officers to be profilers, they should have an awareness of the different presenting behaviours to assist in their decision making and signposting especially when there are dual allegations. With this incident it could be perceived that Bob was a violent resistor using violence either to keep himself safe, an immediate reaction to the assault or possibly having enough of the abuse. Clare had not wanted to make a statement or proceed with any police involvement, yet the police continued with their actions to safeguard her. Again, Bob was not provided the same opportunities and there does not appear to have been any consideration or thought of Bob being the victim of abuse.

17.2.6 To mitigate the risk of victims not being recorded (which happened to Bob in 2016), Essex Police now have the Domestic Abuse procedure, within this there are Self Defence and Counter Allegations guidelines. Officers are encouraged to avoid jumping to conclusions about which of the parties in the relationship is the victim and which is 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.

17.2.7 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 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.

17.2.8 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.

17.2.9 If both parties claim to be the victim, officers should risk assess both. There may also be circumstances where the person who is 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.

17.2.10 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.

[21] https://www.bethepeace.ca/articles-1/michael-johnsons-typology-of-domestic-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.

17.2.11 Where the nature of the allegations is similar and where the level of injury is the same with no obvious corroboration (such as witnesses/third parties), officers are to audit their rationale as to why one party was treated as the victim over the other. Consideration should be given to the arrest of both parties if unable to distinguish who will be treated as the victim.

17.2.12 Physical violence was evidenced within police reports and their interaction with the couple. However, there does not appear to have been any exploration by officers with regards to other forms of abuse. As explained within the statutory definition of the Domestic Abuse Act 2021[22] physical violence is but one form of abuse with emotional, economical, sexual, psychological, and coercive control being abusive behaviours. In December 2015 Section 76 of the Serious Crime Act 2015[23] came into effect criminalising coercive and controlling behaviour. When police were in contact with Bob and Clare in 2016 this piece of legislation was relatively new and may have not been at the forefront of the minds of officers who dealt with the couple. Although Clare declined to provide a formal statement in 2016, she provided officers with some detail regarding Bob's jealousy and that he did not want her to see her friends. This coupled with the previous incidents in 2010 indicated the possibility of coercive and controlling behaviour within the relationship.

17.2.13 Even though coercive and controlling behaviour was not explored, the risk to Clare was identified as high and appropriate interventions were made. It was positive the DASO was proactive in their attempts to engage with Clare, leaving a message for her and 'leaving the door open for contact'. It was also positive they identified the need to create a safety plan with the 'means available to them' as well as referring to IDVA and MARAC.

17.2.14 There was however the missed opportunity to offer Bob similar support from the DASOs after his disclosure. Whether this would have made any difference to Bob or the relationship we cannot determine, but it would have been an opportunity for him to speak to someone and have information of support if/when he wanted it.

17.2.15 Officers identified the risks to Clare and were proactive in seeking and obtaining the DVPO. This provided an opportunity for her to be contacted and seek support should she have wanted to at the time. Although positive safeguarding factor, a DVPO is only short-term protection, and it was evident from information shared that abuse within the relationship had been ongoing for some time meaning this was unlikely to stop once the order expired. It would therefore have been beneficial for a longer-term support and action plan be put in place which could have been created with an effective MARAC.

17.2.16 The panel acknowledge these incidents occurred 6 years prior to Bob's death and there have been significant changes to policing, training, and legislation, these include:

17.2.17 The current risk assessment process as it relates to Domestic Abuse is currently under review by Essex Police having recognised the limitations of the DASH RIC. It is anticipated that the

[22] https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted
[23] Serious Crime Act 2015 (legislation.gov.uk)

current DASH process will be replaced by DARA[24] (used by several forces within the UK and developed by the College of Policing in conjunction with Cardiff University). This evidence-based assessment will replace the formulaic nature of the DASH with a reduced question set and is intended to prompt fuller responses from those being assessed rather than providing Yes/No answers.

17.2.18 With the introduction of DARA there will be greater disclosure from victims particularly around coercive and controlling behaviour by abusive partners (recognised as the precursor to most domestic abuse homicides between intimate partners).

17.2.19 When there are dual allegations made the process is reliant upon those individuals recognising the allegation amounts to a crime and that the matter requires recording followed by a proportionate investigation. To support officers and police staff in achieving this, training is provided and is subject of Continued Professional Development throughout their time with the service, including specific training when new legislation is enacted utilising Computer Based Training and/or traditional face to face training within a classroom environment. Essex Police have developed specific Domestic Abuse training, this has been delivered to all frontline staff and an evaluation has been conducted which received extremely positive feedback. This training consisted of presentations from keynote speakers including psychologist Malcolm Hibberd, Luke Hart & Ryan Hart from Coco Awareness, Lucy Whittaker from Alpha Vesta, and input from specialist DA officers within Essex Police. Additionally, the force obtained over 350 licences for the Professor Jane Monkton-Smith (Homicide Timeline) training to support the learning and development of officers.

17.2.20 Essex Police are currently the only force to have a domestic abuse specialist investigators course (1 week) and they have shared the course timetable with the College of Policing to aid them in designing this as a national course.

17.2.21 Additional guidance and advice are contained within policies and procedures which are always available to staff and are updated regularly. Further guidance and advice can be obtained from specialist teams including the Central Referral Unit, Domestic Abuse Investigation Teams, and Domestic Abuse Problem Solving Teams.

17.3 MARAC

17.3.1 This case was heard at a 'Super MARAC'; this is where two MARACs take place at the same time due to cases being out of time protocols. This would and continues to put pressure on agencies to supply attendees for two separate meetings. Essex MARAC has not been out of Protocol for a long while, even though it is positive they are part of the contingency plan, should the volume become unmanageable, robust oversight is in place to ensure action planning and agency engagement does not slip. Where MARAC holds no statutory footing such as MAPPA (Multi Agency Public Protection Arrangements) or other safeguarding panels, there is no requirement for organisations to attend. When agencies are faced with many different pressures there it means attending meetings can be extremely challenging.

[24] https://www.college.police.uk/article/police-better-equipped-spot-controlling-behaviour

17.3.2 It is evident from the MARAC plan for Clare that agency engagement was poor with only three attending and one providing information. This would not have been following SafeLives MARAC[25] principles and it resulted in no information sharing and the inability of any multi agency working.

17.3.3 It is especially concerning that no IDVA was present at the MARAC and there are no records to explain why. Unfortunately, the IDVA provider at the time no longer hold records dating back to this date and the review has been unable to ascertain whether there were any attempts or contact with Clare. A lack of an IDVA update or presence may have made a difference to engagement, however this cannot be certain. A successful MARAC requires all partner agencies to be present especially that of the IDVA to support and represent the needs of the victim and support a coordinated safety plan.

17.3.4 The action plan was not clear with who was going to carry out the post MARAC call to Clare. This needed to be clear with a time and date for completion. Additionally, a further action could have been for the IDVA to update MARAC of any engagement or the DASO to contact the IDVA to discuss engagement and contact.

17.3.5 Bob's allegation of the assault and Clare's admission was not disclosed and/or discussed at the MARAC. Again, this would and should have been an opportunity to explore within the action plan any intervention and support to Bob as well as Clare.

17.3.6 Since 2016 there have been changes in the MARAC processes with clear action planning and greater agency engagement. Action plans contain far greater information regarding engagement with both victims and perpetrators with opportunities of engagement with both. Actions are also given to agencies in their absence if required and there is far greater information sharing across the partnership in relation to MARAC cases.

17.4 Hertfordshire & West Essex ICB/General Practice

17.4.1 There was limited contact with Bob and health professionals, however there were opportunities for practitioners to have explored his injuries and been open to the possibility he was subjected to domestic abuse.

17.4.2 At the time of his presentation at A&E COVID was at its peak and there were extreme pressures on staff as well as social distancing and wearing of masks. Staff provided Bob with the care he required whilst under such pressure, without any obvious outwardly indicators of domestic abuse, their response to his injury and explanation was appropriate. Even so this may have been an opportunity to have explored how Bob had sustained his injuries in more detail, within the notes it states, 'no safeguarding concerns,' however, it is unclear how this was determined. There is no evidence whether Bob was asked about domestic abuse or safeguarding. Due to him being a carpenter and his explanation of how he obtained the injury it appears it was dealt with on face value. There was also the possibility that due to Bob being male it did not raise the same concerns as if he had been female. It is important frontline staff

[25] https://safelives.org.uk/sites/default/files/resources/The%20principles%20of%20an%20effective%20MARAC%20FINAL.pdf

can identify possible male victims especially when presenting with injuries which may not be obviously because of domestic abuse.

17.4.3 Bob saw his GP on six occasions over six years compared to Clare who saw her GP twenty-seven times. Both presented to the GP with injuries and although they provided reasons how they had sustained the injuries, there was no professional curiosity to seek further clarification of their causes. Neither GP records indicate any disclosures were made, whether it was explored with either patient or noted on their files.

17.4.4 Men's Health Forum[26] found men are less likely than women to use a general practice or visit a pharmacy (women aged between 20 – 40 years are twice as likely to seek support), it also found that men tend to downplay any symptoms or need to seek medical support. They also found there was a clear fear surrounding the potential loss of masculinity and stoicism, instead of honesty about what was happening and being able to accept interventions. This may have been the case for Bob especially with the conversations with the family and how he felt about his role as a man and husband.

17.4.5 When Bob presented at the GP with an injury to his neck and back claiming it occurred due to lifting a heavy board, it appears due to this corroborating with his line of work as a carpenter it did not raise any suspicions. As with A&E, GP surgeries were under immense strain at this time and were facing unprecedented challenges within the health service and with their patients. Therefore, with the presentation of Bob's injuries, the offer of intervention and support was appropriate at the time. However, again this could have been an opportunity for the GP to have explored further detail in how the injuries occurred.

17.4.6 Bob raised with his GP possible financial concerns as he had stated he needed to be well so he could work and could not afford too many days off due to identifying his profession as a self-employed carpenter. These financial concerns may have created a barrier in him seeking health intervention which in turn would have reduced his opportunities to seek support and information not only about his finances but other concerns.

17.4.7 Bob disclosed his drinking and smoking habits to the GP. A Kings Fund study found men are more likely to participate in three or more risky behaviours such as smoking, drinking, lack of exercise and poor diet. It is important that when men attend their GPs, time and attention is paid to the whole picture for the patient rather than just the presenting concern.

17.4.8 This was a missed opportunity for the GP to have had a discussion with Bob when he disclosed his alcohol intake and smoking. It is not clear from the notes what discussions were had, however, the reasons for the high alcohol and smoking consumption could have been explored. He was asked about whether anyone had ever been injured whilst he was drinking to which he replied '*No*.' This raises the issue regarding the possible perception that when men are intoxicated, they are violent rather than them being vulnerable to others. It was positive the GP asked the question to ensure safeguarding of others, but it does not appear they considered him as a victim. Questions which could have then been asked to explore further with '*Has anyone ever hurt you when you have been drinking*?' and '*Can you explain to me the reasons for drinking the level of alcohol you have told me about*?' These questions

[26] ttps://www.menshealthforum.org.uk/key-data-understanding-health-and-access-services

are open and enable a conversation and further questions to be asked dependent on the answer. Closed questions although necessary for risk assessments and forms do not provide the opportunity to probe further.

17.4.9 The Institute of Alcohol Studies[27] found that alcohol use with victims is complicated, and they may turn to alcohol as a means of coping with their experiences of abuse. The recent Domestic Homicide Oversight Report 2023[28] found that of the DHRs in 2020 – 2021 68% of perpetrators were vulnerable with mental health followed by alcohol. Within these DHRs it was evident both victims and perpetrators drank significant amounts of alcohol and had sought support via their GPs however these may have been masked with other ailments.

17.4.10 Victims of domestic abuse may use alcohol as a coping mechanism to 'dull' the impact of the abuse. It can leave them vulnerable to further abuse due to the risk of being unable to protect themselves and the perpetrator using alcohol as a form of abuse. When professionals are working with people who use alcohol, take substances, or have 'unhealthy lifestyles' contributing factors behind the behaviour should be considered.

17.4.11 Clare saw her GP on a regular basis with some routine contacts but there were also several appointments where she had sustained injuries, presented with stress, falls, and requested 'not fit for work' notes which the analysis has focused on.

17.4.12 In 2010 she told police she had sustained a cracked rib due to a domestic incident with Bob (this was also known as an injury by her colleagues), yet it was not noted within her GP notes. She raised concerns about pain in her ribs and/or chest on four occasions between 2016 and 2019. At no point did she make a disclosure of domestic abuse however, it does not appear she was asked whether someone had hurt her or if she was experiencing abuse at home as the notes indicate the pain was due to her work as a nurse. Additionally, there were no records within her notes that her GP was aware she had been heard at MARAC.

17.4.13 The GP noted Clare was on a high dose of codeine for her back pain which was reviewed after her request for it to be increased. There was no mention of her use of alcohol and the level she was drinking within any of her consultations whilst taking the medication. It would have been expected the GP would have asked these questions at the assessment and review, but this is not evident in any records. Even though this would have been expected any response would be reliant on Clare disclosing her alcohol use. A barrier for Clare to disclose her level of alcohol use may have been her role as a community nurse and any possible safeguarding duty the GP may have had to follow.

17.4.14 Clare fell on the stairs and presented with pain in her ribs, she then attended her GP two months later stating she had fallen again three weeks prior to the appointment. She disclosed she had sustained bruising to her face, explaining the medication had caused her to fall and was advised against the pain relief medication and to self-refer to the physio. There does not appear to have been any exploratory questions regarding the 2 falls and bruising to her face. Her accounts appear to have been taken at face value, if she had been asked about domestic abuse it may have provided her an opportunity to have made any disclosures.

[27] Home - IAS
[28] https://www.gov.uk/government/collections/domestic-homicide-review

17.4.15 It would have been beneficial for the GP to have looked at Clare's history, injuries, stress and explored their underlying causes. Professional curiosity would have enabled the GP to have discovered patterns and the bigger picture. There is a barrier for health professionals with the systems used, as all contacts and notes are entered into the same system, meaning valuable information can be lost within the 'reams' of notes. How can we support the notes to remain dynamic? Systems need to remain dynamic; to have the ability to identify clusters of injuries or high-risk factors and to prompt the GP with concerns enabling them to ask further questions join the dots and create a full picture. Without the lack of professional curiosity and routine enquiry by the GP (and other health agencies) there were missed opportunities to have explored domestic abuse for both Bob and Clare.

17.4.16 When Clare presented with an injury of a twisted knee, she stated she had not wanted to bother anyone due to COVID. Between 2016 and 2020 Clare was in regular contact (twenty-two contacts) with the GP citing multiple concerns. After the pandemic there were only five contacts with her GP which is a significantly lower than before. After such regular contact this may have been detrimental to her health and wellbeing and her ability to seek support. She reported another fall within these five contacts. The GP evidences a conversation where she had stated she had missed a step which is a plausible reason for falling. However, with the repeated presentations of falls, injuries, and stress/depression there was another opportunity to have sought further clarification of what was happening.

17.4.17 As well as her injuries and depression Clare requested several 'not fit for work' notes, one is for a bereavement due to the death of her family member (identified as her father). However, no reasons were provided within the notes for both April and May 2021 (her work records note that this was for stress/anxiety/depression). There is no evidence any exploratory questions were asked regarding what was causing her anxiety or stress. If these had been asked there would have been an opportunity for the GP to explore the relationship and Clare to discuss any pressures at home or any domestic abuse.

17.4.18 GPs must have the opportunity to stop and reflect on the consultation or prepare for an upcoming appointment. GPs are facing extraordinary pressures to meet clients, as well as provide e-consultations and other requests. Appointments are back-to-back and if any go over the 10-minute allocated time there is a long-term impact on the entire day for not only the GP, but patients and the rest of the team. This is not a local issue but a national concern with difficulties to retain staff, availability of appointments which impacts on the quality of time patients have with their GP and adds pressures and stress for the medical staff. With all these factors, staff currently struggle to have the opportunities and time to identify patterns and step back and inevitably there will be missed opportunities with victims.

17.4.19 Safeguarding e-learning, training via the J9 Initiative[29] and the Domestic Abuse Protocol are all available across the Essex area, however, there does not appear to be robust follow up of progress and development because of the training. Additional to this training, practitioners need to be able to complete comprehensive notes to evidence conversations with patients.

[29] https://setdab.org/j9-initiative/

17.5 EPUT

17.5.1 No complaints were received by patients regarding Clare, her clinical practice and record keeping were as expected and accurate as well as her being considered a dependable member of staff.

17.5.2 Staff stated they knew Clare was a victim of domestic abuse and had seen injuries, some of them significant. Clare felt able to speak and tell some of her colleagues what was happening at home, which is positive as this indicates she saw them as safe people and a safe environment to make these disclosures. When victims are isolated, work can be the only safe place and it remains imperative, they are supported by their colleagues and employer's. Safelives highlight that the workplace can provide the conducive environment to disclose abuse, so vigilance is required of practitioners to enquire about domestic abuse. The concern arises that although staff were aware of the violence, they were conflicted between their relationship as a supportive colleague and the need to escalate to management and an assumption management knew.

17.5.3 There is no evidence staff escalated any concerns to senior managers or the Director beyond colleague discussions. There is no evidence within Clare's supervision notes of any formal disclosures or discussions regarding domestic abuse with her line manager. If there had been formal disclosures during supervision this would have given the opportunity for the line manager to explore support for her and escalate concerns appropriately.

17.5.4 During this time, the focus on the Trust's safeguarding training regarding domestic abuse was on patient safety and did not include specific guidance for staff suspected of experiencing domestic abuse, therefore there was little guidance to support staff.

17.5.5 The Government created 'Workplace Support for Victims of Domestic Abuse' which provides guidance and information[30]. Workplaces are encouraged to have a robust and user-friendly domestic abuse policy for employees and employers to identify support for victims and provide guidance where there are concerns regarding abusive behaviours.

17.5.6 In December 2021 EPUT commenced the implementation of a staff support process by developing and launching a Staff Domestic Abuse Toolkit alongside an awareness session. The toolkit provides guidance to staff, it highlights the signs of domestic abuse which includes substance misuse, injuries, and repeated time off all which Clare was displaying throughout her career with the Trust. There was a short period between the launch of the toolkit and Bob's murder which may account for some of the lack of awareness of how to respond.

17.5.7 The trust-wide domestic abuse sessions have only been delivered once since December 2021 and the launch of the toolkit is very much a work in progress with over 7000 staff that require access to the training. Currently there continues to be uncertainty of what is expected when staff suspect or know a colleague is subjected to domestic abuse. Each member of staff spoken to for this review was able to demonstrate the expected process and procedures with regards to domestic abuse and safeguarding concerns for patients. However, questions were raised

[30] https://www.gov.uk/government/publications/workplace-support-for-victims-of-domestic-abuse/workplace-support-for-victims-of-domestic-abuse-review-report-accessible-webpage#chapter-1-building-awareness-and-understanding-of-domestic-abuse-among-employers-and-in-workplaces

because of this review of what action would be taken when a colleague has capacity (within the Care Act 2014[31]) and when/how to escalate any concerns identified. As a result of this review the relaunch of the training programme for managers has been rolled out systematically from June 2023. In addition, the Trust Domestic Abuse Policy and Procedure was due for review, a link was developed with a local specialist service Alpha Vesta to create a new co-produced Domestic Abuse Policy and Procedure, this partnership has now developed into the staff training programme.

17.5.8 Current training regarding domestic abuse is routinely provided to all staff within the L3 Safeguarding Training, however this is aimed at patients as per the intercollegiate requirements for health. Due to there being a delay in the roll out of the awareness sessions, EPUT have not been able to evaluate the impact of this, however once this has been provided to all tiers of training there will be an evaluation of the impact and change of practice amongst the Trust.

17.5.9 In November 2022, the Trust Safeguarding Team delivered a domestic abuse awareness event for staff 'How to Break the Cycle of Abuse', 95 members of staff accessed this training. The event was recorded and is available for all staff to access on the Safeguarding Intranet Site. Additionally, in March 2023 the Trust held a "no more week" which consisted of a programme of lunchtime events accessible via MS Teams producing podcasts on Domestic Abuse and offering the opportunity again to view the 'How to Break the Cycle of Abuse' recorded event, 170 staff attended this session. These are proactive steps to ensure domestic abuse continues to be discussed with the aim of having the risks and signs at the forefront of the minds of all staff within the Trust.

17.5.10 With these initiative-taking steps to training and the toolkit in place, there are still concerns of the varied actions by staff with regards to their response to domestic abuse. The panel asked how EPUT could evidence the difference all these measures had made. They were able to demonstrate there were two recent cases where the safeguarding team and managers were supporting staff as well as an increase in requests for consultations and support. This is positive however, there continues to be vigilance on how staff respond, record, and act.

17.5.11 As already mentioned within the analysis Clare's supervision records do not show any discussion, concerns, safety planning, signposting, or support with regards to domestic abuse or alcohol. The Trust has an Appraisal and Support policy and procedure which includes a one-to-one support template that is used for one-to-one sessions with staff. This ensures a written and signed record of the meeting is kept by the employee and line manager. One-to-one records are confidential and are not subject to audit. Compliance with the mandatory supervision periods is reported via the Trust supervision tracker which is monitored in accordance with the Trust's governance process to the Trust Board, commissioners and CQC. It is recognised that there was a lack of record keeping of the 'non-formal' concerns raised by staff to managers, this may have been due to informal discussions rather than in a formal capacity, however, we cannot be certain of the reasons.

17.5.12 A review has been completed on Clare's sickness records with a conclusion her absences were managed in line with Trust sickness absence policy and procedure except for documented

[31] https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

weekly catch-up calls from her line manager. However, there were periods where Clare was off 'long term sick' or had individual sickness days with the majority citing either anxiety/stress/depression or other psychiatric illness or musculoskeletal problems. She had a total of 270 days of sickness between 2016 and 2021. Of these 270 days, 230 were taken in the fourteen months leading to Bob's death which equates to approximately 75% absence from work (on average there are 260 working days in 1 year). ONS data[32] states that in the year 2021 the average worker had 4.6 days of sickness in a twelve-month period, therefore her absence was significant. Surprisingly, her supervision/sickness records note she had a reasonable sickness absence record, and no concerns were ever raised. It is not evident whether she was asked by her manager about her stresses at home however, during her last period of sickness she was offered support via the EAP and Occupational Health which is positive as they identified she may need additional support (even though this was not taken up).

17.5.13 The Director of EPUT has oversight of all long-term sickness cases which are reviewed monthly to ensure appropriate progress and support is being provided to line managers and the staff member. Clare's sickness was never raised due to her illnesses not triggering the Bradford Factor[33].

17.5.14 With such significant time off work there was a possible financial impact on the couple. Research by Vodafone and KPMG found that the potential loss of earnings per female victim of abuse is £5,800 each year. This is a significant amount of money, and as already highlighted within this report there were already concerns regarding the economic situation within the relationship.

17.5.15 When she sent a text to a friend to say she was an alcoholic and wanted to kill herself this was raised to a manager which is in line with the Trusts Alcohol and Drug Policy. However, these concerns were not escalated to senior management and therefore no written documentation of the concerns and action were taken as expected within the policy. It is unclear whether Clare was spoken to at all about her alcohol use or whether the manager was concerned regarding her care of patients or driving. Although there appears to have been no action taken with regards to the alcohol use the manager did make proactive steps to support Clare with regards to her mental wellbeing by contacting the Employment Assistance Programme (EAP) who advised she call the CRISIS team on 111. This was all relayed to Clare who stated she would speak with her GP. It is unclear why the manager did not speak and record any conversations regarding the alcohol at the same time or investigate what the 'stressors' were to try and support her.

17.5.16 Bob's family requested the panel consider a recommendation for NHS staff working with vulnerable people to have random drug and alcohol testing. There was much discussion at the panel with regards to this request, proactive measures were taken to identify other employers who carry out random or intelligence led testing. Members of the panel were able to determine processes already in place with regards to disciplinary policies, drug and alcohol policies and referrals into the National Midwifery Council for any specific action such as these.

[32] Sickness absence in the UK labour market - Office for National Statistics (ons.gov.uk)
[33] https://www.bradfordfactorcalculator.com/

Therefore, it was felt the recommendation was not required and this was fully explained and relayed to the family.

18. Conclusion

18.1 The tragic death of Bob has highlighted the complexities of abusive relationships especially where there is violence by both parties with addiction to alcohol. Bob has been unable to have a voice within this review, but we have made every attempt to ensure his voice has been heard throughout. Clare, by not taking part in the review, also has no voice in its content. Little is known of the dynamics of the relationship or the true extent of the abuse however, with the bravery and honesty of Bob's family and Clare's colleagues, as well as the openness of those services who encountered the couple, the panel has utilised all the information available to seek learning and take forward recommendations for the future.

18.2 When we consider Bob's loyalty to his marriage vows and his wife along with societal beliefs of 'how men should behave' it is not surprising he did not share what was happening within the relationship. Bob faced several possible intersectional barriers when considering speaking or seeking support, these barriers were:

- Being male.
- His belief system.
- Perception by police as the perpetrator.
- Substance misuse.

18.3 All these intersecting layers meant the abuse Bob was subjected to was not identified and he was never considered as a 'victim of domestic abuse,' and although he was asked in interview about his relationship, no DASH RIC was completed after his disclosure. Clare was continually perceived as the victim no matter what disclosures were made.

18.4 Kimberlee Crenshaw (who coined Intersectionality in the 1980's) states *'Without frames to allow us to see how social problems impact all the members of a targeted group many will fall through the cracks and suffer'*. Bob did not fit the 'frame' of services who were in contact with him and therefore he was never treated in the same way as a female victim.

18.5 Whilst Clare was identified as the victim by police and thought as a victim by her colleagues there was no consideration of her being the possible aggressor even with her admission and observations by Bob's family, although we cannot be certain this could have been due to her:

- Being a woman.
- Presenting as a victim.
- Role as a nurse.

18.6 These varied factors may have caused unconscious bias for those who encountered the couple. We all need to be aware of unconscious bias, how it can impact the way we ask questions, how we can make assumptions especially when we think of who a 'typical victim and perpetrator' might be. At times due to these thought processes, we subconsciously avoid these conversations which can be detrimental in the offers of support and intervention. For practitioners, friends, families, and communities to overcome barriers in speaking to those

who may be subjected to or using abusive behaviours any training and awareness needs to unravel and confront those unconscious bias's we all have.

18.7 This review has highlighted that although Bob and Clare had contact with professionals and colleagues, details of any discussions were never recorded which has caused difficulty in understanding decision making and actions taken. It is essential those who are working frontline are confident in how to write their case notes as well as mechanisms to review staff notes and actions ensuring they are accurate, factual, and relevant. Even if conversations had happened with Clare, to explore the risks and support options, it is unlikely it would have changed her drinking habits outside of her working hours.

18.8 To support practitioners with their awareness and confidence in asking the right questions, there needs to be a package of different methods. For example, Elizabeth Bates found the use of pictures and images rather than 'traditional questions', with regards to exploring what was happening to men subjected to abuse, as well as the impact, received a far more positive and engaged response. Therefore, how we ask men questions needs to become routine but unlike those used for women where the trauma and experience will be different. Bates found that only 4% of male victims had ever been asked by a professional if they were subject to domestic abuse compared to the routine questioning of women. Asking questions about the relationship and injuries has been a recurring theme throughout this review with repeated missed opportunities for both Bob and Clare. We must remember that even if those questions had been asked, both had capacity under the Care Act 2014 to make their own choices and decisions even if from the outside, they appeared unsafe.

18.9 Clare appears to have had a finality of thinking, she had told her colleague she wanted to kill herself and her internet searches were of either suicide or murder. Jayne Monkton-Smith discusses in her book *'In Control'* and the '*Homicide Timeline – Stage 7 Planning'*, that planning is a contentious issue, because if we accept that killers plan murders it cannot be a crime of passion or a moment of losing control. Even though both were violent to each other, on the night of Bob's death Clare knew what action she was taking. There is the possibility she did not mean for him to lose his life when she stabbed him, however she stabbed him twice, would have known the risks and refused to treat his injuries whilst on the phone to the call handler. Her use of alcohol could be considered as an explanation for the murder, but as already noted in this review it does not cause someone to be abusive and is a contributing factor enabling someone to take risks they may not usually take.

18.10 None of us know what conversations or actions happened between Bob and Clare that night or why she chose that evening to do what she did. What we do know is that Clare made the decision to stab Bob taking his life away when it was not hers to take.

19. Learning and Recommendations

Learning Point 1

There needs to be an increased awareness of domestic abuse including the additional barriers, complexities, and intersectionality victims (especially men) face when in an abusive relationship. This will enable communities and professionals the knowledge of how to offer a safe space to seek and offer help and support.

Recommendation 1
Develop a co-ordinated and multi-agency domestic abuse awareness campaign including male victims, and victims who have additional complexities such as mental health and substance misuse.

Learning Point 2
Health professionals are working under continued pressure with regards to their time and what support they can offer patients. Much of the population have a GP and although it is unlikely for a patient to make a direct disclosure of domestic abuse, ailments/injuries may be dealt with in isolation rather than to form a picture. It is therefore important all health professionals feel confident recognising possible signs of domestic abuse and how to approach victims and those using abusive behaviours.

Recommendation 2
All healthcare staff to receive additional training and resources to better recognise signs of domestic abuse especially with regards to male patients and those with additional complex needs. Any training should include the potential biases practitioners may have when recognising abuse with men compared to the recognition of abuse for women. Additionally, there needs to be an understanding of how male victims may present, and how their health concerns such as alcohol or mental health may be as a result of abuse within a relationship.

Recommendation 3
All GPs and practice staff (including receptionists) should have domestic abuse awareness training, to enable them to raise any concerns to the practice safeguarding lead for further risk assessment and appropriate action.

Learning Point 3
Given that domestic abuse and alcohol misuse was common knowledge by Clare's colleagues, the line manager could have triggered a more exploratory conversation with her. As part of the Trust's one to one supervision procedure, all employees are required to have a wellness plan in place which should be reviewed and where required updated during one-to-one support/supervision meetings. During these meetings managers should refer to the appropriate policy and procedure for guidance and seek HR support where applicable, for example the Domestic Abuse Toolkit and the Alcohol, Drug or Substance Misuse policy.

Recommendation 4
EPUT policies to be appropriately linked to the domestic abuse toolkit – including Employee Wellbeing sickness and absence policy, one to one support and appraisal policy.

Recommendation 5
EPUT to provide record keeping advice and guidance within the Domestic Abuse Training and Management Training.

Recommendation 6
EPUT Supervision Policy and template to add domestic abuse to any safeguarding concerns and how to escalate concerns and actions in supervision notes.

Learning Point 4

There continues to be sporadic involvement of statutory and non-statutory agencies at MARAC (and was also the case in 2016) this causes issues with relevant information sharing, highlighting risks and creating a SMART[34] action plan. There are no statutory requirements for agencies to attend or take actions, which is dangerous and a missed opportunity to share information and explore interventions for those involved.

Recommendation 7

MARAC to be given a statutory framework and requirement for agencies to attend and be proactive members of the discussions and action plans.

[34] **S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**imely

SETDAB | Southend, Essex & Thurrock Domestic Abuse Board

Domestic Homicide Review

Harlow Community Safety Partnership

Bob died February 2022

Executive Summary

Report Author Katie Bielec

18th July 2023

Contents Page Number

Foreword

The Foreword is made up of memories from Bob's family and close friends.

Bob worked hard as a cabinet maker and took pride in his work. He was a sociable character, loved to socialise with a pint. He was happy go lucky and football mad, he loved Tottenham Hotspurs. As a brother he was loving, caring and full of wise words, and when he had a drink, we only heard words of love and affection, never any aggression. Bob was an exceptionally loyal man; notably caring, warm, and kind, with an inherent desire to protect those he loved and who loved him, he was the gentlest, most loving, and loyal person. He would do anything for you, and we never felt anything other than being loved and safe in his presence. He loved to laugh and share the warmth and love he had for his family and close friends.

The entire process has been extremely emotionally draining and stressful for the family starting with one of his sons having to identify his body. It has been extremely hard to have no explanation or understanding as to why Bob lost his life. Our family cannot understand why a trained and 'dedicated' nurse left Bob to die whilst she was downstairs refusing to give first aid. We have been unable to identify any emotional or real remorse from Clare. It has also been hard to hear him be painted as an aggressive and violent drunk who would regularly harm Clare when we have only experienced a kind, gentle and loving man.

Bob will never get to meet his grandchildren, his great nieces, and nephews. A huge hole has been left in our family. Bob might be lost to us physically, but he is with us forever in spirit, we love you forever.

Preface

Harlow Community Safety Partnership (CSP)[35], panel members and the author wish at the outset to express their deepest sympathy to the family of Bob. This review has been undertaken in order that lessons can learnt; we appreciate the engagement from his family throughout this difficult process. The chair of the review aimed to work with the family sensitively and with compassion.

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 death in a meaningful way and address with candour the issues that it has raised.

1. Introduction

1.1 This review is a statutory requirement which will examine agency responses and support provided to Bob (not his real name) and that of Clare (not her real name) prior to his murder. The Executive Summary summarises the events leading to Bob's death and the conclusion of the panel's findings. For full analysis into the interaction agencies had with both Bob and Clare please refer to the Overview Report.

[35] CSP – Community Safety Partnership

2. Timescales

2.1 In February 2022 Bob was murdered by his wife Clare who he lived with in Harlow. Harlow Community Safety Partnership received a Domestic Homicide Review referral from Essex Police, the decision to carry out the review was made in March 2022, an Independent Chair and Report Author was commissioned in April 2022.

2.2 The Home Office Multi-Agency Statutory Guidance for Domestic Homicide Reviews 2016, paragraph 46 states that the target timescale for completion of the review of six months. Initial information was sought by Southend, Essex, and Thurrock Domestic Abuse Board (SETDAB)[36] to ensure different agencies were aware of the DHR and the requirements as well as the introductory panel meeting. However, the review was unable to be completed in six months due to the on-going criminal case which concluded in September 2022, which caused a delay in any contact with family, friends, or colleagues. Additional detail was also required by the chair causing further delay. This delay was approved by Harlow CSP and the panel, there were a total of 4 panel meetings for this review.

3. Confidentiality

3.1 In line with Home Office Statutory Multi-Agency Guidance paragraph 75, to protect the identity of those involved and to comply with the Data Protection Act 1998 pseudonyms have been used which were chosen by Bobs' family and agreed by the panel.

3.2 The sharing of information between agencies in relation to this review was underpinned by the Information Sharing Protocol which is in place to facilitate the exchange of personal information to comply with the requirements of Section 9 of the Domestic Violence, Crime and Victims Act 2004.

3.3 Panel meetings were confidential and any sharing of information to third parties was carried out with the agreement of the responsible agency's representative, the panel and chair.

3.4 The findings are restricted to authors of the reports, their managers and panel members. Once agreed by the Harlow CSP, the Home Office will be informed and will be presented for final approval. Initial learning identified through the review process will be acted on immediately.

4. Methodology

4.1 DHRs became statutory in 2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states: 'A DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:

a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death'.

[36] SETDAB - Southend, Essex and Thurrock Domestic Abuse Board

4.2 Agencies were identified to provide IMRs[37] after scoping was completed across the Essex area. The terms of reference were provided to all agencies completing IMRs. All reports, learning, recommendations, and actions were quality assured by senior members of staff within each organisation.

4.3 In addition to the IMRs provided by agencies the chair was also provided with:

- Invaluable family insight into Bobs' background and his relationship with Clare.
- Statements made by family for the criminal trial.
- Judge's sentencing remarks.
- Criminal court agreed facts.
- Recording of the 999-call made to Police by Clare.

4.4 Various pieces of research have been used within the analysis and are referenced throughout.

5. Involvement of family and friends

5.1 Bob's family were informed of the DHR by letter, they were referred to Victim Support – Homicide Support Team and were supported by an advocate from this service. The chair remained in contact with the family and advocate throughout the entirety of the review.

5.2 After the criminal trial Clare was informed of the DHR, provided with the Home Office Statutory Guidelines, and offered the opportunity to meet or speak with the chair, unfortunately, this was declined. No details were available regarding contact with Clare's family however her colleagues were spoken to by the chair.

6. Contributors to the review

6.1 IMRs were provided and presented to the panel by:

- Essex Police
- Essex Partnership University NHS Foundation Trust (EPUT)
- Hertfordshire & West Essex ICB

6.2 The panel comprised of agencies recommended within the statutory guidance, specialists for domestic abuse, male victims, and Clare's employer (EPUT). The review panel consisted of:

Agency	Representative and role
Chair	Katie Bielec
Essex Police	DS Ben Pedro Anido - T/Detective Inspector, Head of Operational Development within the Strategic Vulnerability Centre Jules Bottazzi - Head of Strategic Vulnerability Centre DS Scott Kingsnorth - TSA DI | T/Head of Operational Development, Crime and Public Protection Command DI Lydia George - Senior Investigating Officer (SIO)
Hertfordshire & West Essex Integrated Care Board (ICB)	Beaulah Chizimba - Interim Designated Nurse Safeguarding Adults Zivai Muyengwa - Designated Nurse Safeguarding Adults

[37] IMR - Individual Management Review require agencies to look openly and critically at individual and organisational practice.

Harlow Community Safety Partnership	Christine Howard - Strategic Manager for Community Safety, Youth and Engagement / Designated Safeguarding Officer
SETDAB Team	Emma Tulip-Betts – Specialist Wellbeing & Public Health Officer
Essex Partnership University Foundation Trust (EPUT)	Nicole Rich - Director West Essex Community Physical and Mental Health Services Tendayi Musundire - Associate Director for Safeguarding
Adult Social Care – Essex Council	Elaine Oxley - Director of ASC Safeguarding and Quality Assurance
Next Chapter (Domestic Abuse Service)	Nicola Taylor – Service Manager
Male Victim Specialist Service - Safer Places	Gemma Toynton – Independent Domestic Violence Advocate (IDVA)
Open Road – Substance Misuse Service	Joni Thompson - Clinical & Business Development Director
Alpha Vesta	Lucy Whittaker - Chief Executive Officer

7. Author of the Overview Report

7.1 Katie Bielec is an independent domestic abuse consultant, she is an accredited chair with AAFDA[38] and SILP[39] and MARAC[40] , has completed the Home Office Domestic Homicide Review Training, is a member for AAFDA DHR Network, Standing Together Against Domestic Abuse Coordinated Community Response (CCR) and The Employers Initiative on Domestic Abuse (EIDA). She is an associate trainer for Safelives, Rockpool, The Hampton Trust, a guest lecturer at Bournemouth University and is an accredited trainer delivering Coercive Controlling Behaviour and Stalking. Katie was previously a Metropolitan Police Officer, she is a qualified IDVA, IDVA manager, ISVA[41] Manager and managed domestic abuse services for 11 years.

7.2 Katie is not associated in any way to any agency who have provided information for the review or had any personal or professional involvement with Bob, Clare, or their families.

8. Parallel Reviews

8.1 A criminal trial was held in August 2022, Clare was found guilty of murder and sentenced to life in prison with a minimum of 17 years.

9. Equality and Diversity

9.1 The chair and panel members considered whether any of the protected characteristics within the Equality Act 2010[42] were relevant within the review. Bob was a 57-year-old white British male; Clare is a white British female and was 51 years old at the time of the murder. Bob did not have a disability; Clare had been diagnosed with fibromyalgia, this was not recorded as a disability and no information was provided to believe either had any religious beliefs.

[38] Advocacy After Fatal Domestic Abuse - https://aafda.org.uk/
[39] https://www.reviewconsulting.co.uk/silp-reviews/
[40] MARAC – Multi Agency Risk Assessment conference.
[41] ISVA – Independent Sexual Violence Advocate, support for victims of sexual violence/abuse.
[42] https://www.gov.uk/guidance/equality-act-2010-guidance

9.2 Bob's sex was taken into consideration for this DHR as a risk factor due to domestic abuse and domestic homicides of men with female perpetrators being significantly fewer than female victims and male perpetrators. A recent review of DHRs found 20% of victims were male with female perpetrators equating to 17%[43]. Therefore, the panel felt it important to understand if Bob faced barriers in identifying the abuse and seeking support as well as agency responses.

10. Dissemination

10.1 Bob's family and all agencies involved in the review are aware that the Overview Report and Executive Summary will be published on the SETDAB website[44] and shared with Safer Harlow Partnership Board, Essex Police Fire &Crime Commissioner and the Domestic Abuse Commissioner once agreed by the Home Office; however, the action plan has already been disseminated with all relevant agencies to ensure immediate action and learning can be taken forward. Harlow CSP and chair will work with the family and other partners with regards to any public/press interest.

11. Homicide the facts

11.1 The night prior to Bob's death, he had been to a public house where he met friends, Clare had been at work (as a community nurse) with a fellow colleague and student, her shift finished at 23:00 hours.

11.2 When he returned home, Clare was already at the property and was using the computer which was situated downstairs. The couple drank alcohol together, at some point during the evening Clare alleged Bob called her '*worthless and/or useless'*. At about midnight Clare supported Bob upstairs, helped him to get into his pyjamas and into bed. She went back downstairs, continued to drink red wine, and search the internet whilst Bob went to sleep.

11.3 Shortly after 02:00 hours the following morning Clare went to the kitchen, selected a knife, went to the bedroom where Bob was asleep, and stabbed him twice in the stomach. She called 999 and requested ambulance and police. Clare refused to provide Bob any help whilst on the phone to the call handler who repeatedly asked her to stem the blood flow. Paramedics attended the address and took Bob to hospital where he underwent surgery but later died.

11.4 Toxicology found Clare had 138 milligrams and Bob had 152 milligrams of alcohol per 100 millilitres in their blood at the time of the murder[45].

12. Family and relationship background

12.1 Bob was born in Enfield in 1964. His mother passed away in 2012, his father was 89 years old (at the time of Bob's death), and he had two siblings an elder and younger sister. The family moved to Harlow in the 1970s and have remained there ever since. He met his ex-wife Joyce (not her real name), and they had three children together (all are now adults), after the marriage ended the children remained living with Joyce, however, Bob saw them regularly.

[43] https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews#introduction
[44] https://setdab.org/
[45] 80 milligrams of alcohol per 100 millilitres is the legal limit to drive a car.

12.2 In 2004 Bob met Clare at a local social club and married in 2007, she had never been married and had no children. Clare wanted children but Bob had not wanted any more, this apparently caused some resentment and jealousy in his relationship with Clare. Bob worked for a local furniture company (however, he identified to agencies as a self-employed carpenter), and Clare had been a community nurse in the Harlow area for 16 years.

12.3 Bob would attend the local public house with his father every Friday to play darts and his father would go to the couple's home every Sunday for lunch. He continued contact with his sisters; however, this was limited due to Clare's behaviour whilst intoxicated.

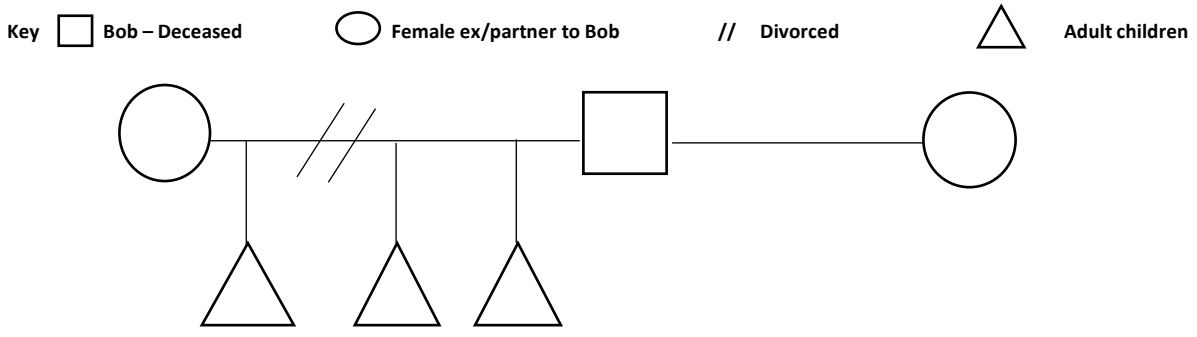
12.4 The family witnessed Clare being violent and abusive to Bob, both within the family home and in public. The impact of the abuse meant Bob's children had limited contact with him for several years, however, after the COVID restrictions were lifted (summer of 2020) Bob began to rebuild his relationship with his youngest son.

12.5 The family do not believe Bob would have identified himself as a 'victim' of domestic abuse although he recognised his relationship was not healthy and at times 'toxic'. They refer to Bob as a dedicated husband, Clare was his priority, and he was committed and loyal to her. They are clear they do not believe he would have sought support regarding the abuse. They describe him as very private, and they do not believe even if they or friends had approached him, he would have made any disclosures.

12.6 Clare has two brothers (who do not live locally to the Harlow area), they had limited contact, and any communication was via phone calls, both Clare's parents have passed away.

12.7 Unfortunately, the review was unable to speak with Bob's colleagues, however Clare's colleagues engaged with the review. They described her as a kind, compassionate and patient nurse who loved her job and worked very hard. She was proud of her work and wanted to a happy life, everyone went to her for advice or support, and she always worked at a fast pace. They were completely shocked and devastated by her actions. Until she was promoted, she also worked as a bank nurse for a private health care service. Clare did not socialise or have contact with her colleagues outside of work and would only attend organised 'work nights out', during these occasions her behaviour had not raised any concerns when she had been drinking.

13. Genogram



14. Chronology

14.1 Details relevant to the review have been identified outside the timeframe set in the terms of reference, unfortunately information is limited, however, the following has been established:

14.2 2002 Joyce reported to Police that Bob had caused her alarm and distress and criminal damage to her property, he was intoxicated at the time, and he pleaded guilty at court.

14.3 January 2004 Police were called to a verbal disagreement between Bob and Clare, both were under the influence of alcohol. Bob had an injury to his knuckle but gave no information in how he sustained the injury. No complaints were made, and no action was taken.

14.4 In December 2004 Clare called Police stating Bob had punched her in the mouth causing cuts and swelling. Bob stated he had attempted to restrain Clare resulting in her biting his calf causing bruising, this occurred in front of Bob's children. No further action was taken by Police.

14.5 Between 2008 and 2018 Clare's colleagues noticed that Clare would go to work with bruises, black eyes, bruising around her wrists, broken ribs and she was at times very distressed due to the environment at home, her colleagues were aware of the domestic abuse.

14.6 In May 2010 Clare called Essex Police on 999 stating that she had been assaulted by Bob at their home address, Bob was arrested and taken into custody. Clare was intoxicated so seen later that day, providing a statement and photographs of her injuries. She alleged Bob had also assaulted her in February 2010 pushing her over causing her to fall against a coffee table cracking a rib. A DASH RIC[46] was completed, she was assessed as high risk. Bob was interviewed, charged with assault (battery), and bailed with conditions whilst he awaited trial.

14.7 Clare informed a Domestic Abuse Liaison Officer (DALO) she was seeking advice from a solicitor regarding a divorce, she declined all other support but expressed anxiety about giving evidence at court. In August 2010 Bob appeared at Magistrates Court where CPS[47] offered no evidence, and the case was dismissed, the reasons for this were not recorded.

14.8 January 2016 Clare presented at her GP[48] surgery on three occasions, on each occasion she was seen by a different GP. She disclosed pain in her back, rib cage, general pain on both sides of the chest wall, pain in her right leg and left arm as well as feeling generally tired. She also informed the GP she was a heavy cigarette smoker; it was also identified her cortisol levels were high. She was given the diagnosis of fibromyalgia and issued a 'not fit for work' note.

14.9 In June 2016 Essex Police FCR received a non-emergency call from Clare. She had fled the home address after being involved in a domestic abuse incident with her partner (she did not disclose who her partner was). The incident was graded as a Priority 1(Urban Emergency), and she was taken to a Police Station where she gave a statement.

14.10 Clare stated the day before she had met up with a close male friend who she had known for twenty years; she had no other close family or friends. She then met Bob at a local public

[46] DASH RIC – Domestic Abuse, Stalking and Harassment Risk Indicator Checklist
[47] Crown Prosecution Service
[48] GP – General Practitioner a medical doctor who treat acute and chronic illnesses and provides preventive care and health education to patients.

house where they had a few drinks before returning home. There was an argument, Bob slammed a cupboard door resulting in a glass being smashed. He had then grabbed her to the back of the head and with the other hand had hit her on the forehead with a glass ashtray causing an injury (lump to forehead). She had left the home fearful of what may happen next.

14.11 The allegation was 'crimed' and a DASH RIC completed. During the assessment Clare described an assault where Bob had used a piece of wood and threatened to kill her (this had taken place six-seven years earlier). She spoke of historical strangulation, jealousy, and feeling isolated. As a result of the information Clare was assessed as high risk, Bob was arrested on the same day at the home address for the offence of Actual Bodily Harm (ABH).

14.12 Bob was interviewed under caution; he gave an account in which he stated an argument had occurred at the home address which resulted in him slamming a door causing a glass to break. Clare had then struck him on the chin with an ashtray (when arrested and entering custody it was noted that he had a cut to his chin), he had reacted by holding the back of Clare's head and pushing the ashtray hard against her forehead asking her, "*how do you like it?*". After he let her go, Clare threw a glass at him and then left the home address. Bob accepted that what he had done was wrong and he should have walked away but had reacted after being assaulted. Following the interview Clare was spoken with by the case officer where she confirmed that she had hit Bob first with an ashtray causing the injury to his chin.

14.13 Clare was advised that a file would be submitted to the CPS and that Bob would remain in custody whilst advice was sought. Clare declined to provide a statement informing that she would not support a prosecution, nor would she attend court. The CPS determined the required threshold test had not been met and no further action was taken in relation to criminal charges. However, given the allegation provided by Clare and the assessment of risk a DVPN[49] was authorised and served on Bob prior to his release.

14.14 Essex Police referred Clare for IDVA support[50] and MARAC. The Domestic Abuse Specialist Officer (DASO) made attempts to contact Clare by phone, but she did not answer the calls, a discreet message was left on her answer phone. A skeletal safety plan was created by the DASO including flagging her home address and phone and to treat all calls as urgent.

14.15 Bob appeared at the magistrates' court two days after the initial allegation where a DVPO[51] was granted for fourteen days. Police contacted Clare on the day of the DVPO, she told the officer she could not speak and hung up, the investigation was filed.

14.16 The case was heard at MARAC, present were Children's Health, Children's Social Care and Police. The only organisation to share information for the MARAC Action Plan was the Police, there was no IDVA update, so engagement was unknown. There is no record of Clare being aware of the MARAC or being contacted after the meeting with any updated actions.

14.17 Clare disclosed to a colleague that Police had been called. She told them she loved Bob and could not go through with taking him to court. There had been discussions of her leaving, but she had stated she did not want to leave him, her home, or her cats so felt it was never a

[49] DVPN – Domestic Violence Protection Notice - A temporary protective order granted by the courts for victims of domestic abuse where police.
[50] The IDVA provider at the time had no information to share due to their Retention Policy had recently changing from 2 years to 5 years.
[51] DVPO – Domestic Violence Protection Order – Temporary Protective Order granted by the courts when there are no other enforceable restrictions.

realistic option for her. Staff stated it had become the '*norm*' for Clare to come in with injuries, a colleague had raised her concern with a manager and there was an assumption management were supporting her. There is no recorded evidence Clare was spoken to by her manager.

14.18 In June 2017 Clare was seen by the Physiotherapy assessment and treatment team due to back pain (reason provided was due to her work as a nurse) and discharged in August 2017.

14.19 Clare was promoted to a Band 6 community nurse in January 2018. In May 2018 she experienced a sudden bereavement and saw her GP who provided a 'not fit for work note' due to stress and was off work for twenty days.

14.20 The GP contacted Clare by telephone regarding medication for her back pain in November 2018, she was offered a face-to-face appointment where medication was reviewed, no details of the cause of back pain was documented. She then attended A&E regarding chest pains, palpitations, and muscular pains (detail of the cause or treatment provided was unavailable).

14.21 Bob's GP referred him for an orthopaedic appointment due to problems with neck pain after an incident carrying a large board in January 2019, an appointment was made for February.

14.22 In February 2019 Clare was seen at the GP surgery with rib pain from a fall on the stairs, medication was requested (it is not documented what caused the fall or if medication was provided). She disclosed to the GP in April 2019 that she had fallen on the stairs three weeks previously, she had fallen headfirst and sustained facial bruising (there is no record the cause of the fall and if this was the same fall in February). She was advised against different remedies, to exercise, and self-refer for physiotherapy, she was diagnosed with neck pain.

14.23 In June 2019 Clare had two days of sickness at work citing anxiety/stress/depression. The GP received a letter from Healthy Minds (a psychological service) in July who saw her for insomnia and depressive disorder. She was advised to start Mirtazapine with a six–eight-week review (there is no indication that this happened).

14.24 Clare attended the GP on two occasions in December 2019 and was provided a 'not fit for work' note citing stress (her absence report at work cites anxiety/stress/depression/other psychiatric illnesses). No details were recorded with regards to the cause of the stress.

14.25 Whilst off work, EPUT referred Clare to Occupational Health in January 2020, provided her with the Employee Assistance Programme (EAP) contact details and advised to see her GP as soon as possible for support. A further Occupational Health telephone review was arranged for February 2020. Clare did not contact the EAP as advised. Clare kept EPUT updated with regards to the Healthy Minds follow up and GP advice, she was off work for a total of 118 days and returned with a recommended three-week phased return by Occupational Health.

14.26 The UK experienced the COVID Pandemic from March 2020 with the population subjected to a nationwide lockdown between 23/03/2020 – 21/06/2020, with a gradual easing of restrictions throughout the summer of 2020.

14.27 In July 2020 Bob was referred for Physiotherapy due to his neck pain not improving. In September Bob attended A&E (alone) after he had fallen and slipped down the stairs six weeks

earlier. He received a hip examination; X-ray of his pelvis and the GP was notified of his attendance. There is no record of the cause of the fall. In October he saw his GP due to 'hip power' and knee buckling/giving way, this was attributed to potentially a result of heavy lifting. Clare also saw her GP reporting her being stable on Citalopram.

14.28 There were two further lockdowns in November 2020 and January 2021 with phased 'easing of restrictions' until June 2021.

14.29 Clare reported to her GP in February 2021 that she had twisted her knee twice but did not want to bother anyone during COVID and bought a support from Boots. She reported to have fallen after she had missed a step resulting in a swollen knee.

14.30 Clare was referred to Occupational Health in March 2021 after an MRI scan identified arthritic changes and damage to Anterior Cruciate Ligament. Clare was advised to wear a knee brace and take anti-inflammatory medication. She was unable to bend down and had difficulty getting up, it was recommended work restrictions for three months with no heavy lifting and to only drive locally if fit and to return to work for office type duties.

14.31 At the end of March 2021 Bob attended a health check, during this appointment he was asked about his alcohol intake and stated he drank one or two units. When asked how often he drank eight units or more on one occasion he stated weekly. He was asked if he or anyone had been injured because of his drinking he replied 'no'. Bob said no relative, friend or professional had been worried about his drinking. He identified himself as a smoker and did not want to quit.

14.32 The GP issued Clare a 'not fit for work' note (no details provided with regards to the reason) in April and May 2021. It was recorded within her work Absence Report this was for 'Other musculoskeletal problems', she was off from work for a total of 106 days.

14.33 Two weeks prior to Bob's death Clare sent several text messages to a colleague (on a work phone), one stated she was an alcoholic and she wanted to take her own life. She declined the offer to be collected by the member of staff. Concerns were raised to a manager with regards to Clare's welfare and her patients. The manager sought advice for Clare's mental health via the organisations 'Hear for You' advice and support where they were advised for her to contact the EAP or the crisis team on 111. This advice was given by the manager, unfortunately there is no record to evidence the concerns of her alcohol use were raised or discussed.

14.34 A few days later Clare's colleague contacted 'Staff Engagement Champion' and the 'Freedom to Speak Service'. She was advised Clare should call 111 or attend A&E if in crisis.

14.35 The same member of staff told Clare of the action she had taken, Clare appeared to understand and remained in contact with them. Clare sent one message stating she had drunk alcohol every day in the last three years apart from eleven days and that Bob drank alcohol with her. These messages were not responded due to the member of staff being on holiday.

14.36 Police found between January 2022 and the night of the murder multiple internet searches had taken place on the computer within the home (it was identified that Clare was the main user of the computer as Bob did not use IT equipment), the searches included:

- Domestic Abuse and Suicide.
- Sodium thiopental (a rapid onset short acting barbiturate general anaesthetic).
- Murders and capital punishment.
- Death row inmates.
- Fatal car crashes.
- Fatal car crashes where drivers were drunk under the influence.
- Deaths caught on camera/tape.
- Police shootings.
- Interviews with serial killers before execution.
- Alcohol intoxication.
- Mothers killing children.

15. Conclusion

15.1 The tragic death of Bob has highlighted the complexities of abusive relationships especially where there is violence by both parties with addiction to alcohol. Bob has been unable to have a voice within this review, but we have made every attempt to ensure his voice has been heard throughout. Clare, by not taking part in the review, has had no input either. Little is known of the dynamics of the relationship or the true extent of the abuse however, with the bravery and honesty of Bob's family and Clare's colleagues, as well as the openness of those services who encountered the couple, the panel has utilised available information to seek learning and take forward recommendations for the future.

15.2 When we consider Bob's loyalty to his marriage vows and his wife along with societal beliefs of 'how men should behave' it is not surprising he did not share what was happening within the relationship. Bob faced several possible intersectional barriers when considering speaking or seeking support, these barriers were:

- Being male.
- His belief system.
- Perception by Police as the perpetrator.
- Substance misuse.

15.3 All these intersecting layers meant the abuse Bob was subjected to was not identified and he was never considered as a 'victim of domestic abuse', and although he was asked in interview about his relationship, no DASH RIC was completed after his disclosure. Clare was continually perceived as the victim no matter what disclosures were made.

15.4 Kimberlee Crenshaw (who coined Intersectionality in the 1980's) states *'Without frames to allow us to see how social problems impact all the members of a targeted group many will fall through the cracks and suffer'*. Bob did not fit the 'frame' of services who were in contact with him and therefore he was never treated in the same way as a female victim.

15.5 Whilst Clare was identified as the victim by Police and thought as a victim by her colleagues there was no consideration of her being the possible aggressor even with her admission and observations by Bobs' family, although we cannot be certain this could have been due to:

- Being a woman.
- Presenting as a victim.

- Role as a nurse.

15.1 These different factors may have caused unconscious bias for those who encountered both Bob and Clare. We all need to be aware of unconscious bias, how it can impact the way we ask questions, how we can make assumptions especially when we think of who a 'typical victim and perpetrator' might be. At times due to these thought processes, we subconsciously avoid these conversations which can be detrimental in the offers of support and intervention. For practitioners, friends, families, and communities to overcome barriers in speaking to those who may be subjected to or using abusive behaviours any training and awareness needs to unravel and confront those unconscious bias's we all have.

15.2 This review has highlighted that although Bob and Clare had contact with professionals and colleagues, details of any discussions was never recorded which has caused difficulty in understanding decision making and actions taken. It is essential those who are working frontline are confident in how to write their case notes as well as mechanisms to review staff notes and actions ensuring they are accurate, factual, and relevant. Even if conversations had happened with Clare to explore the risks and support options it is unlikely it would have changed her drinking habits outside of her working hours.

15.3 To support practitioners with their awareness and confidence in asking questions there needs to be a package of different methods. For example, Bates found the use of pictures and images rather than 'traditional questions' with regards to exploring what was happening to men subjected to abuse as well as the impact, received a far more positive and engaged response. Therefore, how we ask men questions need to become routine but not the same as we use for women as the trauma and experience will be different. Bates found that only 4% of male victims had ever been asked by a professional if they were subjected to domestic abuse compared to the routine questioning of women. Asking questions about the relationship and injuries has been a reoccurring theme throughout this review and there were repeated missed opportunities for both Bob and Clare. We must remember even if those questions had been asked, both had capacity under the Care Act 2014[52] to make their own choices and decisions even if from the outside they appeared unsafe.

15.4 Clare appears to have had a finality of thinking, she had told her colleague she wanted to kill herself and her internet searches were of either suicide or murder. Jayne Monkton-Smith discusses in her book 'In Control' and the Homicide Timeline – Stage 7 Planning, that planning is a contentious issue, because if we accept that killers plan murders it cannot be a crime of passion or a moment of losing control. Even though both were violent to each other, on the night of Bob's death Clare knew what action she was taking. There is the possibility she did not mean for him to lose his life when she stabbed him, however she stabbed him twice, would have known the risks she was taking and refused to treat his injuries whilst on the phone to the call handler. Her use of alcohol could be considered as an explanation for the murder, but as already noted in this review it does not cause someone to be abusive and is a contributing factor enabling someone to take risks they may not usually take.

[52] https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

15.5 None of us know what conversations or actions happened between Bob and Clare that night or why she chose that evening to do what she did. What we do know is that Clare made the decision to stab Bob taking his life away when it was not her life to take.

16. Learning and Recommendations

Learning Point 1
There needs to be an increased awareness of domestic abuse including the additional barriers, complexities, and intersectionality victims (especially men) face when in an abusive relationship. This will enable communities and professionals the knowledge of how to offer a safe space to seek and offer help and support.

Recommendation 1
Develop a co-ordinated and multi-agency domestic abuse awareness campaign including male victims, and victims who have additional complexities such as mental health and substance misuse.

Learning Point 2
Health professionals are working under continued pressure with regards to their time and what support they can offer patients. Much of the population have a GP and although it is unlikely for a patient to make a direct disclosure of domestic abuse, ailments/injuries may be dealt with in isolation rather than to form a picture. It is therefore important all health professionals feel confident recognising possible signs of domestic abuse and how to approach victims and those using abusive behaviours.

Recommendation 2
All healthcare staff should receive additional training and resources to better recognise signs of domestic abuse especially with regards to male patients and those with additional complex needs. Any training should include the potential biases practitioners may have when recognising abuse with men compared to the recognition of abuse for women. Additionally, there needs to be an understanding of how male victims may present, and how their health concerns such as alcohol or mental health may be as a result of abuse within a relationship.

Recommendation 3
All GPs and practice staff (including receptionists) should have domestic abuse awareness training, to enable them to raise any concerns to the practice safeguarding lead for further risk assessment and appropriate action.

Learning Point 3
Given that domestic abuse and alcohol misuse was common knowledge by Clare's colleagues, the line manager could have triggered a more exploratory conversation with her. As part of the Trust's one to one supervision procedure, all employees are required to have a wellness plan in place which should be reviewed and where required updated during one-to-one support/supervision meetings. During these meetings managers should refer to the appropriate policy and procedure for guidance and seek HR support where applicable, for example the Domestic Abuse Toolkit and the Alcohol, Drug or Substance Misuse policy.

Recommendation 4
EPUT policies to be appropriately linked to the domestic abuse toolkit – including Employee Wellbeing sickness and absence policy, one to one support and appraisal policy.

Recommendation 5
EPUT to provide record keeping advice and guidance within the Domestic Abuse Training and Management Training.

Recommendation 6
EPUT Supervision Policy and template to add domestic abuse to any safeguarding concerns and how to escalate concerns and actions in supervision notes.

Learning Point 4
There continues to be sporadic involvement of statutory and non-statutory agencies at MARAC (and was also the case in 2016) this causes issues with relevant information sharing, highlighting risks and creating a SMART[53] action plan. There are no statutory requirements for agencies to attend or take actions, which is dangerous and a missed opportunity to share information and explore interventions for those involved.

Recommendation 7
MARAC to be given a statutory framework and requirement for agencies to attend and be proactive members of the discussions and action plans.

[53] **S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**imely

APPENDIX 1

Terms of reference

The purpose of the review is to:

- Examine the events leading up to the incident, including a chronology of the events in question.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including challenging systemic issues and making changes to policies and procedures as appropriate.
- Improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

Key Issues:

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends, and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- Determine if there were any barriers Bob or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.
- Review agencies response, professional curiosity, interventions, care, and treatment and or support provided.
- Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards, domestic abuse and safeguarding policies, procedures and protocols and ensure adherence to national good practice.
- Determine whether workplace policies are inclusive and enable staff to raise concerns of colleagues where there is suspected domestic abuse (either as a victim or perpetrator).
- Review how organisations can empower employees to feel safe with disclosures of abuse, or concern of another whether in work or outside of the working arena.
- Review the communication between agencies, services, friends, family, and colleagues including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse for male victims.
- Is there a consistency in how agencies respond to victims of domestic abuse when both parties may present to an agency as a victim/perpetrator (possible "bi-directional abuse" and "counter-allegations"), is there any gender bias?
- Was there any impact of the Covid pandemic on those affected by or working with the family?

Harlow DHR "Bob "Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
What is the over-arching recommendation?	Should this recommendation be enacted at a local or regional level? (N.B national learning will be identified by the Home Office Quality Assurance Panel, however the review panel can suggest recommendations for national level)	How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?	Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?	Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved	When should this recommendation be completed by?	When is the recommendation actually completed? What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?
Develop a co-ordinated and multi-agency domestic abuse awareness campaign including male victims, and victims who have additional complexities	Local	Include and work with male victims, those who use substances and who have mental health to assist and support the SETDAB Comms Strategy.	SETDAB	Survivor Forums and lived experience work is already underway and this will be included within these agenda and discussions	31/03/24	This has been passed to the SETDAB Comms group for consideration for a future campaign.

such as mental health and substance misuse.						
All healthcare staff to receive additional training and resources to better recognise signs of domestic abuse especially with regards to male patients and those with additional complex needs. Any training should include the potential biases practitioners may have when recognising abuse with men compared to the recognition of abuse for women. Additionally, there needs to be an understanding of how male victims may present, and how their health concerns such as alcohol or mental health may be as a result of abuse within a relationship.	National/Local	Offer a variety of training available with the recognition of the demands on time for workers, offers to include: • Information updates in team meetings • E-Learning • Face to face learning All GP practices and hospitals to be sent the SETDAB website link to encourage awareness of support available. Practice safeguarding leads to have the information available to support practice staff.	Joint West Essex Local place-based (Hertfordshire and West Essex ICB) Designated Professional Joint West Essex Local place-based (Hertfordshire and West Essex ICB) Designated Professional	This has been a recurrent theme in 2 DHRs in the locality and preparations for the training have been discussed and are progressing.	01/10/23 01/07/23 01/07/23	01/07/2023 Mankind has been commissioned to provide bespoke training regarding male victims - training links have been shared. This has been shared with all Named Nurses and GPs. All practice leads have links and information to support staff within their practice.
All GPs and practice staff (including receptionists) should have domestic abuse awareness training, to enable them to raise any concerns to	Local	Evidence GPs and practice staff to receive Domestic Abuse Training. This training is to include raising awareness of high-risk	Herts & West Essex ICB	Hertfordshire Domestic Abuse toolkit shared.	31/03/24 31/03/24	Herts & West Essex ICB Arranged for Level 3 Children and Adult Safeguarding Webinar on 05/12/2023. Herts IDVA service completed a Presentation with very

the practice safeguarding lead for further risk assessment and appropriate action.		indicators from the DASH.				positive feedback attended by approx. 100. Upcoming session arranged for 28/02/2024.
		Domestic Abuse to be an agenda item within safeguarding practice meetings.	Herts & West Essex ICB		31/03/24	This work is ongoing.
		Consider recommissioning hospital IDVA's and GP Health Advocates (criteria to include men as well as women).	SETDAB/ICB		31/03/25	This work is ongoing.
EPUT policies to be appropriately linked to the domestic abuse toolkit – including Employee Wellbeing sickness and absence policy, one to one support and appraisal policy.	Local	EPUT to review and update policies to ensure there are clear expectations of managers where there are domestic abuse and other safeguarding concerns for staff.	EPUT	EPUT are working with Alpha Vesta, Specialist Domestic Abuse Advisors for Employees to address the "gap "with regard to supporting employees who may be experiencing domestic abuse" as opposed to the focus of the current policy being to support patients.	31/12/23	Completed.

EPUT to provide record keeping advice and guidance within the Domestic Abuse Training and Management Training.	Local	EPUT to update training and any relevant policy.	EPUT		31/12/23	Completed.
EPUT Supervision Policy and template to add domestic abuse to any safeguarding concerns and how to escalate concerns and actions in supervision notes.	Local	EPUT to update relevant polices and templates to support managers regarding domestic abuse.	EPUT		31/12/23	Completed.
MARAC to be given a statutory framework and requirement for agencies to attend and be proactive members of the discussions and action plans.	National	Domestic Abuse Act 2021 to be reviewed and MARAC included within the legislation.	Domestic Abuse Commissioner		01/04/24	Report has been shared with the Domestic Abuse Commissioner for her to consider his recommendation.

Home Office

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15th February 2024

Dear Emma,

Thank you for submitting the Domestic Homicide Review (DHR) report (Bob) for Harlow Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21st December 2023. I apologise for the delay in responding to you.

The QA Panel felt the review kept the victim at the centre especially with the moving tribute provided by the victim's family. The QA Panel were pleased that condolences were offered to the family, which represents good practice. It was positive to see that the family were engaged throughout the DHR process, for example the fact that they were able to choose the pseudonyms used in the report.

The QA panel also comment the inclusion of a male domestic abuse (DA) specialist on the DHR panel, and they welcomed the discussion around both individuals potentially being perpetrators of DA. They also welcomed the discussions around the barriers the victim faced in terms of support, using Home Office statistics to aid understanding. The overall report was well-constructed and easy to read with some good learning included. There was also a good use of research within the report.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

• Further clarity could be provided around the panel's independence and why the police make up a larger proportion of the panel.

• There is contradictory language in paragraph 11.1 and paragraph 16.11 regarding the details around the perpetrator's fibromyalgia diagnosis and this should be amended. In addition, the entire report should be checked for spelling errors and references and the recommendations in the action plan should all have milestones and outcomes listed.

• Paragraphs 13.1 and 13.3 detail the exact date of death and it is recommended these references are removed to respect anonymity.

• The QA panel think there was lack of professional curiosity and routine enquiry by health agencies for example the GP.

• There were missed opportunities by the police to identify the victim as a victim of domestic abuse and a domestic abuse, stalking and 'honour'-based violence (DASH) should have been completed.

• The dissemination list should be more reflective of who will be in receipt of the report once approved for publication and should include the PCC and DA Commissioner.

• While the panel commented that it was positive it was acknowledged that both individuals could have been perpetrating domestic abuse, it was also estimated that Clare's experiences of abuse (including economic abuse) were minimised at times explaining them as only being in relation to Bob's self-defence. In paragraph 14.2, it was also felt that the explanation for Clare's resentment towards Bob was assumptive.

• More information could have been provided on how the perpetrator was invited to contribute and the nature of her colleague's involvement in the review.

• Reference to the employers and accessing support was missing.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk . This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This

should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel