Tewkesbury Community Safety Partnership

DHR- Ann

Death- September 2015

Review Concluded April 2018

Final

Executive Summary

Independent Chair –Deborah Jeremiah

THE REVIEW PROCESS

This summary outlines the process undertaken by Tewkesbury Borough Community Safety Partnership Domestic Homicide Review Panel in reviewing the homicide of Ann who was a resident in their area.

The following pseudonyms have been used this this review for the victim and perpetrator to protect their identities and those of their family members:

Victim: Ann

Perpetrator: Fred

Ann and Fred's daughter: Sue

Criminal proceedings were completed in March 2016, and the perpetrator was found guilty of murder and jailed for life (a minimum of 11 years and nine months).

The process began with an initial meeting of the Community Safety Partnership in October 2015 and the decision to hold a Domestic Homicide Review was agreed. All agencies that potentially had contact with Ann and Fred prior to the point of death were contacted and asked to confirm whether they had involvement with them.

Five of the agencies contacted confirmed contact with the victim or the perpetrator and were asked to secure their files.

CONTRIBUTORS TO THE REVIEW

The agencies which contributed to the review were:

Gloucestershire Domestic Abuse Support Service (GDASS) – specialists in domestic abuse, provider and understanding of services and issues for victims of domestic abuse.

Gloucester Constabulary - Public Protection and County Domestic Abuse and Sexual Violence Strategic Coordinator - Statutory agency as per Section 9 of the 2004 Act, specialist in domestic abuse and ongoing strategic development of services. Agency involvement with Fred and contributor of IMR for this review.

Gloucestershire Education Authority – Agency involvement as Ann's employer and contributor of an IMR for this review.

2Gether NHS Foundation Trust, Tewkesbury Borough Council – Agency involvement with Fred and contributor of an IMR for this review.

NHS Gloucestershire CCG – involvement with Fred and Ann as well as a contributor of IMR for this review

Tewkesbury Borough Council – Statutory agency involvement as per section 9 of 2003 Act.

Five Agencies confirmed they had contact with Ann and/or Fred and were asked to secure their files. At a later date one of these agencies, a social housing provider, confirmed that their contact had been with a different couple who had the same name and ceased involvement with the review.

The IMR authors were selected by each agency on the basis that they were independent of any involvement with any party considered within this DHR. The school IMR was however collated by the head teacher of the school in which the victim worked, who also had a personal relationship with the victim. The decision was made to allow this on the basis that vast amounts of information were known by this individual and the panel felt her IMR was open and transparent. To ensure an element of independence however, the County Council Education Department and LADO were consulted and reviewed the IMR on behalf of the panel and contributed where necessary to any recommendations and actions.

THE REVIEW PANEL

Heather Downer – Gloucestershire Domestic Abuse Support Service (GDASS)

Mark Chicken – Detective Chief Inspector (now Det.Superintendent) Public Protection, Gloucestershire Constabulary

Rebecca Scutt - Head Teacher, Gloucestershire Education Authority

Sophie Jarrett - County DASV Strategic Coordinator, Public Protection, Gloucestershire Constabulary

Peter Tonge – Head of Community Services, Tewkesbury borough Council

Dr. Katy McIntosh – GP for Safeguarding Adults and Children, NHS Gloucestershire CCG

Alison Feher - Safeguarding Lead, 2Gether NHS Foundation Trust (Mental Health)

Ann and Fred's daughter, Sue, contributed greatly to the review, as did Ann's brother. Some close relatives declined the opportunity to take part in the review, which is to be respected however this may limit the review as not all perspectives have been captured. However this has not been considered to prejudice the review as input from family and friends who wished to contribute has enabled the panel to build a reasonable profile of Ann and Fred.

The panel met on five occasions to consider the review. The panel members were independent to the review, with the exception of the Head Teacher – who was Ann's employer and therefore knew her professionally. This panel member was included due to significant knowledge in relation to the circumstances of the case and the level of involvement the school had with Ann. The IMR and report was however independently reviewed by the County Council Education Team and LADO to ensure a level of independent scrutiny.

REQUIREMENT FOR A REVIEW

The decision to undertake this DHR is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely as possible, professionals need to understand fully what happened in each homicide and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The review will also consider of single agency and partnership involvement with the parties to draw out the strengths and weaknesses

TIMESCALES

- The Home Office Statutory Guidance advises that where practically possible the Domestic Homicide Review should be completed within 6 months of the decision made to proceed with the Review. Due to unforeseen circumstances of which the Home Office are aware, this was not possible.

- The Home Office were notified of the DHR on 21st October 2015

- The criminal proceedings concluded in March 2016

- The DRR panel met on five occasions with the final meeting being on 11th September 2017.

- Consultation of family members for the proposed final report occurred between October 2017 and April 2018.

AUTHOR OF THE OVERVIEW REPORT

Deborah Jeremiah – The Independent Chair was also the author of the review report and has a health and legal background. She has been conducting DHRs since 2008 and is fully independent of Tewkesbury Borough Community Safety Partnership. The independent chair has not worked for any agency in the area previously.

TERMS OF REFERENCE FOR THE REVIEW

1. Whether in all the circumstances at the time, any agency or individual intervention could have potentially prevented Ann's death.

2. Review current responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what should have happened and review national best practice in respect of protecting adults from domestic abuse.

3. Examine the roles of the organisations involved in this case; the extent to which Ann and Fred had involvement with those agencies, and the appropriateness of single agency and partnership responses to this case to draw out the strengths and weaknesses.

4. Establish whether there are lessons to be learnt from this case about the way

in which organisations and partnerships carried out their responsibilities to safeguard and protect the wellbeing of the victim.

5. Identify clearly what those lessons are.

6. Identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in the county in order to better safeguard victims of domestic abuse.

7. Consider how services can detect risk in a domestic relationship, especially when outwardly it may look that all is well?

8. How can services support family and friends share information that an individual may be at risk within their relationship?

9. How can services support employers and colleagues to share any relevant information that may indicate domestic abuse or risk?

10. What is the best practice professional response when an individual contacts the police exhibiting unhappiness around their relationship and possibly seeking help?

11. How can services support couples with serious relationship difficulties to navigate through this safely?

12. How can services support and safeguard an individual who may need to leave the relationship?

SUMMARY CHRONOLOGY

The review indicated there was little awareness of discord in Ann and Fred's relationship until the start of the new school year in September 2015. Information from the few weeks preceding Ann's murder is largely based on discussions between Ann and several different colleagues at the school as her friends and confidantes. During this time Ann advised individual colleagues that she was seeing a solicitor to divorce Fred, that Fred was following her, and told her to be careful when she was sleeping.

The identified key events were:

Key event 1 -In early September 2015 Ann told colleagues she was advised by her solicitor to stay in the matrimonial home to protect her assets.

Key event 2 – In early September Ann asked to speak to a Parent Support Advisor (PSA) at her work for help and advice. She described Fred taking her house and car keys for long periods and that she had been locked out of her house at times.

Key event 3 – In early September 2015 Ann told the PSA that Fred had taken her cards and blocked her access to all bank accounts. Ann tells the PSA that Fred had taken her passport and birth certificates.

Key event 4 – Early September 2015. Ann told colleagues that Fred said he would have her mentally assessed and she believed he could and would do this. He also accused her of having child pornography on her laptop.

Key event 5 – Mid September 2015. Fred contacted the Police Force control room and discussed his marriage breakdown at length with a call handler for the police

Key event 6 – Mid September 2015. The Head teacher spoke to Ann regarding allegations made by Fred that she was having an affair and that her partner was interested in young children. Ann was advised to take spare clothes and keys to a friend's house in readiness to leave. Ann advised she was looking for a flat and did not want to go home. She also told the Head teacher that Fred was coming into her room at night behaving in a sexually inappropriate way. Ann also told her colleague that she was placing her chest of drawers in front of her bedroom door to stop Fred.

Key event 7 – Mid September 2015 – Fred was seen by his GP. He told the GP that he had found out his wife was cheating on him and his world had collapsed. The GP assessed Fred and suggested he have some support from a mental health nurse but Fred declined.

Key event 8 – End September 2015. Ann tells colleagues Fred would be receiving the divorce papers and she was scared to go home.

End September 2015. Ann is murdered by Fred.

KEY ISSUES ARISING FROM THE REVIEW

This review highlights a short timeline of significant incidents which occurred exclusively at the end of Ann and Fred's relationship. Ann did not seek help from the statutory services or agencies regarding Fred's behaviour as their marriage broke down. Her disclosures to colleagues were shared as confidences to friends, and no one person had an overview of the disclosures Ann made. Some colleagues did advise and signpost Ann to more formal advice and suggested to her that she left the house. The concept of coercive control was generally less well understood in 2015. Fred did contact both his GP and the Police Control Room to communicate his distress that his relationship had ended; and both agencies discussed this at length with him and considered there was no indication that he was a risk to Ann, himself, or others. Given that Ann had not been known to services, and Fred had not come to the attention of services or agencies in a concerning manner, there was little opportunity to consider the relationship in terms of domestic abuse and risk.

CONCLUSIONS

The review panel concluded that the death could not have been foreseen.

LESSONS TO BE LEARNED

Family lawyers risk providing inappropriate advice if they do not explore the dynamics of the relationship and if there are any features of domestic abuse and risks that may be attached to that dynamic.

The national guidance for employers where there are concerns for employees who may be a victim of domestic abuse was not considered or followed in this case. Ann herself did not raise this with HR and her colleagues saw her difficulties as a personal matter.

The lack of understanding and awareness of coercive control at the time acted as a barrier to fully recognise Fred's behaviour to Ann as abusive.

Employees when faced with concerning information from a colleague around possible domestic abuse or any other safeguarding matter should utilise HR via the Head Teacher for advice and support or encourage the colleague making the disclosures to do so.

The management of the Police call handler is an example of good practice. Reviews should highlight and share examples of good practice.

The impact of a separation point in an intimate relationship where there is non acceptance by one party and evidence of previous abusive behaviours may increase the risk of harm.

RECOMMENDATIONS FROM THE REVIEW

Tewkesbury Borough Community Safety Partnership (TBCSP) should write to the Law Society and Association of Family Lawyers bringing their attention to this DHR and ask them to consider issuing appropriate guidance.

TBCSP should use this review to highlight to multi-agency employers/employees that there is national guidance in place for HR that can support the concerns of an employee experiencing domestic abuse.

TBCSP endorse the ongoing development of multi-partner awareness training around coercive control.

TBCSP to endorse and support the DASV Concordat and take steps to highlight the role of HR in supporting employees who may be experiencing any element of domestic abuse.

The good practice of the call handler from the Police Force Control Room should be shared and commended across the partnership

This DHR outcomes should be shared with primary care clinicians. This review acknowledges this insight by primary care and adopts the IMR recommendation but the GP in this case demonstrated good and thoughtful process.