Domestic Homicide Review

Executive Summary

Report into the Death of 'Mrs. A'

Died 2017

2nd March 2020

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1. INTRODUCTION

1.1 The Review Panel extends their deepest condolences and sincerest thanks to Mrs. A's family and the members of the community who contributed to this review.

1.2 In line with the agreement of the victim's next of kin, the principal people referred to in this report are:

'Mrs. A' Victim (Adult female 1)

'Mr. B' Perpetrator (Adult male 1)

1.3 Mr. B contacted Leicestershire Police. He stated that he had murdered his wife after there being difficulties in their marriage. The Police attended the family home. Mr. B, who was still at the address, was arrested on suspicion of murder, and was cautioned. Mr. B was subsequently charged with Mrs. A's murder and, in line with local protocols, the Police informed the Community Safety Partnership of the homicide.

1.4 Mr. B was found guilty of the murder and sentenced to life imprisonment.

1.5 The sentencing Judge stated that he was satisfied that:

- The evidence presented to the Court confirmed that Mrs. A had endured years of abuse perpetrated by Mr. B.
- Mr. B was a controlling man who sought to isolate Mrs. A because of an unsubstantiated belief that she was having an affair, despite others assuring him this was untrue.
- Mr. B also subjected Mrs. A to extreme psychological abuse, and this increased in the weeks prior to her death.
- Mr. B had disposed of the murder weapon, and that he had purchased it some weeks before he killed Mrs. A, and Mrs. A was aware of the purchase and that the item would be used to kill her.

2. ESTABLISHING THE DHR

2.1 The Chair of the relevant Community Safety Partnership decided the case met the criteria for a Domestic Homicide Review (DHR) and appointed Chris Thomas as the independent Chair. An independent report author, Cherryl Henry-Leach, supported Mr Thomas. A DHR Panel was assembled which represented local agencies and included members with detailed knowledge of domestic abuse and persons with specialist knowledge relevant to the case.

2.2 Seven agencies submitted written information, and interviews were held with members the community who knew Mrs. A. Mr. B also agreed to meet with the report author in prison.

2.3 The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

3. BACKGROUND

3.1 Introduction

3.1.1 From the evidence presented to it, the Panel found that Mrs. A was controlled by Mr. B from the start of their marriage, and throughout it.

3.2 Mrs. A

3.2.1 Mrs. A is generally described as someone who was well-liked by all that knew her, who kept herself to herself and had few close friends, and even fewer confidants. From the discussions with all who knew her, the loss of Mrs. A has been heartfelt and distressing, and this indicates how well thought of she was. There was a collective consensus that Mrs. A loved her husband, was faithful to him and worked hard to ensure her marriage was a success. Mrs. A is described by a friend as a very lovely person who sought to please. Those closest to Mrs. A recalled that they would sometimes feel frustrated that Mrs. A would not stand up for herself because she (Mrs. A) did not want to cause anyone discomfort or distress by her actions. Mr. B was interviewed in prison. When invited to do so, he also described Mrs. A as a “nice person who would do anything for anybody” but was reluctant to expand on any further discussion about his wife and her personality or the dynamics of their relationship, saying that it was too upsetting for him to do so.

3.2.2 Mrs. A was in employment and, during the months prior to her death, she has been described by those who knew her “as growing in confidence, enjoying

the money she was earning…and beginning to realise she no longer had to depend on Mr. B for financial support…she had flourished".

3.2.3 Mrs. A was also described as someone who kept herself to herself. As a result, the Panel found that she was isolated within her community with a very small social and family network. Mrs. A maintained a high level of privacy so that her actions, or her marriage, did not become the subject of conversation within her community. The Panel found that Mrs. A's isolation was significantly increased and enforced by Mr. B towards the end of her life.

3.3 Mr. B

3.3.1 Mr. B shared very little about his background. Those that knew him described Mr. B as extremely religious. Although some stated that they did not observe him to be violent toward Mrs. A, there was a general consensus that he treated her unkindly throughout the course of their marriage.

3.3.2 Mr. B claimed to have accidentally caused the injuries that killed Mrs. A during an argument.

4. COMMENTARY

4.1 Minimal agency involvement was a feature in this case.

4.2 The Panel found that policies and procedures that existed at the time of involvement were followed. Those have since been updated. With the benefit of hindsight, the Panel found that identification of potential indicators of coercive control required improvement, and they made recommendations from this review to support the ongoing activity that is facilitating this. The Panel was informed by research that indicated victims from some or particular communities were unlikely to disclose sensitive issues such as domestic abuse to professionals from their community, and so there was a need to ensure that potential indicators of domestic abuse were probed sensitively in safe environments with the use of independent linguistic support where required. The Panel also found that awareness raising activity was required within the community in which Mrs. A lived to increase awareness of:

- domestic abuse, including coercive control
- the need to safeguard vulnerable adults and children experiencing domestic abuse through third party reporting
- how to support victims of domestic abuse who are not ready to leave their abusers
- understanding of safe domestic abuse professional practice when providing support to those who perpetrate domestic abuse.

5. KEY FINDINGS AND RECOMMENDATIONS

Key Finding 1 – Supporting Practitioners

Practitioners who are likely to work with family members, including children, are to be supported, through training and reflective practice, to recognise and respond to the typologies of domestic abuse.

Recommendation 1

Domestic abuse training and guidance for reflective practice is to include material that will support practitioners to recognise and respond appropriately to the typologies of domestic abuse, including

- domestic abuse, including coercive control
- the need to safeguard vulnerable adults and children experiencing domestic abuse through third party reporting
- how to support victims of domestic abuse who are not ready to leave their abusers
- understanding of safe domestic abuse professional practice when providing support to those who perpetrate domestic abuse.

This will require a training refresh by individual agencies involved.

Key Finding 2 – Professional Curiosity

In order to recognise that abuse may be a feature of someone's life, we need to ensure that we are looking for indicators of it – even when explanations appear plausible – and that we record that this has been considered, in addition to our sharing of information which can enable others to make informed decisions about assessments and interventions.

Recommendation 2

All agencies are to be reminded to keep in mind the links between child abuse, neglect and domestic abuse, as well as the links between domestic abuse and physiological causes. This may require a training refresh for individual agencies.

Recommendation 3

Practitioners are to be routinely reminded of the importance of accurate and timely record-keeping through the insertion of this reminder in all training linked to domestic abuse, child and adult safeguarding by the Leicester, Leicestershire and Rutland Domestic Abuse & Sexual Violence Operational Group following this review. This may require a training refresh for individual agencies.

Key Finding 3 – Supporting Employers to Support Employees

Employees who experience abuse should be supported regardless of gender and the type of abuse. The workplace can be a lifeline for survivors of domestic abuse as it offers an opportunity to seek help. By providing opportunities for employees who are affected by abuse to remain in work, we can support their wellbeing over the long term.

Recommendation 4

The Leicester, Leicestershire and Rutland Domestic Abuse & Sexual Violence Operational Group will consider how large employers such as Mrs. A's employer and other local employers are supported in their development of a domestic abuse policy.

Key Finding 4 – Spiritual guidance and informal support where domestic abuse is a feature

Where domestic abuse is a feature for a family, spiritual guidance and informal support needs to be undertaken in a manner that does not escalate the risk posed by the perpetrator to the victim. We need to be sure that those giving such support are supported to recognise situations where this is likely to be the case and respond appropriately.

Recommendation 5

The Council of Faiths, with support from the Leicester, Leicestershire and Rutland Domestic Abuse & Sexual Violence Operations Group, to progress the development of training that is informed by safe domestic abuse practice in relation to assessment of remorse, and signposting advice when domestic abuse is identified in spiritual counselling sessions that aligns with the scriptural teachings.

Key Finding 5 – Policy and Pathway Development

Staff within community services are very likely to hear from their users of concerns in relation to children, young people and adults who are at risk of harm. We need to support staff to be aware of their obligations in relation to safeguarding, even when concerns are shared informally or are in relation to third parties that do not access our services. We also need to be sure that our policies provide the appropriate information, advice and guidance, including the response to reports of domestic abuse.

Recommendation 6

Leicestershire and Rutland Safeguarding Adults Board and Safeguarding Children Partnership are to support community services and partners to refresh their safeguarding policies so that they are clear on the statutory

obligation to share concerns to safeguard children and adults at risk of harm, including third party reports, and contain clearly defined pathways on how to undertake this.

6. CONCLUSIONS

6.1 The Panel concluded that Mrs. A was subjected to coercive control throughout her marriage to Mr. B, and this was exerted by Mr. B. Months before her death. Mrs. A experienced increased and significant isolation from her small network. The Panel noted that Mrs. A was subjected to extreme coercive control, which left Mrs. A feeling humiliated with little choice but to be compliant to Mr. B's demands.

6.2 They also concluded that the significant coercive control that Mrs. A experienced prior to her death resulted from Mr. B fearing that he had lost control over Mrs. A, due to her increased confidence.

6.3. Due to the extremely limited agency involvement with Mrs. A and her family, particularly in weeks prior to her death, professionals were unaware of this being the lived experience of Mrs. A. As a result, the Panel concluded that no opportunity presented that would have enabled any professional to assess the risk posed to Mrs. A. It follows that there was no opportunity to assess how Mrs. A viewed her situation as a victim of domestic abuse, facilitate any risk assessment, undertake the level of appropriate risk reduction activity, or any offender management.

6.4. The Panel was supported by discussion with members of Mrs. A's community who very bravely gave insight into the gender dynamics that were a factor for Mrs. A. These discussions enabled the Panel to recognise that, whilst the community were aware that Mrs. A was being subjected to domestic abuse by Mr. B, from discussions with members of Mrs. A's family and community, the Panel found that there was a belief within her community that domestic abuse without violence, could not be reported by third parties if the victim of the abuse was reluctant or unable to report in person.

6.5 The Panel found that the community was aware that domestic violence was an offence, but not domestic abuse or coercively controlling behaviour. The Panel also noted that the structures and social fabric of the very closely-knit community in which Mrs. A lived were a relevant feature.

6.6 Given the historical context of agency involvement with members of the family, the Panel concluded that this review has highlighted the need for a holistic whole family approach when working with a family, and specifically where domestic abuse is a feature. The Panel also found evidence to suggest that knowledge about coercive control amongst professionals is not as embedded as it could be within the Partnership, given that exerting coercive control is now a criminal offence.

6.7 The Panel, after reviewing all of the evidence available to it, concluded that professionals involved with this family were not aware of domestic abuse being a feature of this family's life in the weeks that preceded Mrs. A's murder. In this sense, the death of Mrs. A, based on the knowledge known to those agencies around the time of her death, was not predictable or preventable.

6.8 Again, the Panel extend their deepest condolences and sincerest thanks to Mrs. A's family and the members of the community who contributed to this review.

APPENDICES

APPENDIX A – DEFINITION

Domestic Abuse (DA)

The definition of domestic violence and abuse, as amended by Home Office Circular 003/2013 which came into force on 14th February 2013, is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

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

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Therefore, the experiences of Mrs. A fall within the various descriptions of domestic violence and abuse.

Nationally, the preferred term is domestic abuse as opposed to domestic violence, and this is used in the report.

The following links are relevant to this DHR:

http://www.safelives.org.uk/practice-support/resources-marac-meetings

https://www.cps.gov.uk/sites/default/files/documents/legal_guidance/OD_000049.pdf

https://mappa.justice.gov.uk/connect.ti/MAPPA/view?objectId=9423508#9423508