DOMESTIC HOMICIDE REVIEW CASE 1:

EXECUTIVE SUMMARY

MAY 2014

Safer Devon Partnership

INTRODUCTION

1. This report of a domestic homicide review (DHR) examines agency responses and support give to Subject X, a resident of North Devon prior to her death in June 2011. The review seeks to identify agency involvement with Subject X, and Subject Y, her long term partner of 12 years, who has been convicted of her murder. It was conducted by the Safer Devon Partnership on behalf of the Safer North Devon Community Safety Partnership, and approved by the Home Office after which additional detail was included.

2. The key purpose for undertaking DHRs is to enable lessons to be learned where a person is killed as a result of domestic violence. In order for these lessons to be applied as widely and thoroughly as possible, professionals need to be able 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.

3. In this instance the Core Strategy Group oversaw the gathering of information provided the identification of the key point of the case. An Independent Chair with a professional background in public sector regulation was appointed to steer this review. The Chair has knowledge of community safety, partnerships and domestic abuse, has never been employed by any of the agencies concerned with this review, and has no personal connection to any of the people involved in the case. The Core Strategy Group is made up from representatives of:
    - Devon County Council
    - Devon & Cornwall Police
    - NHS Devon
    - Adva (Against Domestic Violence and Abuse Partnership)

4. The report examines any engagement between Subject X and Subject Y and agencies prior to Subject X's death. (A fuller overview report is available to the agencies responsible for responding to domestic abuse, but is not in the public domain as it contains personal information about the victim, who may be identifiable from news reports.)The evidence received from agencies suggests that to the point of the murder, the only engagement with public agencies in Devon by either of the subjects was through the medical needs of Subject X, which resulted in a series of appointments at the Royal Devon and Exeter NHS Trust during 2011. These were not the result of any form of domestic abuse or violence.

5. The review report draws on information and analysis from the agencies which were potential support agencies for Subject X prior to her death. A number of local agencies checked their records for any contact with Subject X and her partner. Relevant records were received from Devon and Cornwall Police, and Royal Devon and Exeter NHS Foundation Trust. The report was written by the Independent Chair. Insights from friends and colleagues of Subject X were taken

into account through evidence they had given to the criminal investigation. As Subject X had no living relatives, contact with her family was not a consideration.

CIRCUMSTANCES OF THE HOMICIDE

6. Subject X was murdered by her long term partner, Subject Y, at their home, which was an isolated rural property. On the evening of the homicide she had made arrangements, in his presence, to stay elsewhere for the night, following an argument about his behaviour. He had drunk too much alcohol to be able to drive her home from a day surgery appointment as planned. She then returned with him to their home to prepare, and the murder took place within the next hour. No calls to emergency services were made at the time, and the death was not discovered by the police until the following day.

CONCLUSIONS AND RECOMMENDATIONS

Was there a record of domestic abuse?

7. There is no indication that there was a history of domestic violence between Subject X and Subject Y. No injuries or disputes had been reported to public services. During the criminal investigation police found no accounts of abuse observed by or discussed with other contacts. Subject X had her own source of income and means of communication and transport. She had confided some concerns about the relationship to friends and colleagues, but not in terms that indicated that it was abusive. She had indicated both to Subject Y and to friends that she wanted to end the relationship, but hoped that Subject Y would first complete building work on their home to make it more saleable.

8. The couple were both were of White British ethnicity, and not disabled. Subject X was a professional woman who, through her job, was aware of the impact of domestic violence in the home, and aware of the help available to both victims and perpetrators.

9. During the criminal investigation, police found that Subject Y had a criminal record from the period when he lived in Australia in the 1980s. He was convicted there of indecent dealings with a child (his step-daughter) and of an assault on his ex-wife. This history was not known to the UK criminal justice system prior to the homicide. There is no evidence as to whether Subject X was aware of it. Subject Y's ex-wife indicated that she was not a victim of domestic abuse during their marriage: the assault occurred later.

Could the homicide have been predicted or prevented?

10. The homicide could not have been predicted by public agencies, or prevented by their action. It is a reminder that such tragedies can occur in households where there has been no prior indication of domestic abuse.

11. There were opportunities within the area where Subject X lived and worked for her to obtain help if she had been concerned about actual or potential abuse. However, we acknowledge that it may be very difficult for a professional to expose vulnerability and seek help from agencies they work alongside.

What can be learned to improve future practice?

12. The Core Strategy Group has hosted a seminar for professionals to share lessons from the three domestic homicides which occurred in Devon in 2011. Some factors indicated, though not proven in this case, are therefore worth noting.

    a) *Alcohol.* Subject Y had been had been drinking heavily in the afternoon before the murder occurred although it is unclear whether this affected his behaviour at the time of the murder.
    b) *Isolation*. While Subject X worked outside the home in a professional role in a nearby town, she does not appear to have had a wide circle of friends. The couple had chosen to live in a very remote property, and to have little contact with neighbours or local social groups.
    c) *Control in relationships as a risk*. The relationship included sexual practices based on control, although apparently with consent. However it is not clear whether there was an abusive level of control before the murder.
    d) *Risk at the point of ending relationships* The killing appears to have been a response by Subject Y to Subject X moving out of the home.
    e) *The scope for GPs to probe* the background to unhappiness presenting as a medical problem. The victim did obtain help from her GP in improving her life through addressing obesity and self-esteem. However no explicit questions about domestic abuse were put to her.

RECOMMENDATIONS

13. Whilst there is no evidence of any engagement with agencies, and no causal link between any of the history and the outcome, some of the findings from Case 2 and 3 DHRs in Devon have been underlined by the circumstances of this case. Therefore, whilst no specific recommendations arise from this report, the recommendations from Cases 2 and 3 that are generally supported by this case are listed here[1]:

    - **Case 2 R1. Encourage an approach to assessment that explores the background to low self-esteem, a particular form of damaging behaviour or lifestyle rather than just treating the symptoms, and ensure that records are kept to show where this has taken place.**

[1] The Executive Summaries from these cases are published by SDP in parallel with the Executive Summary of this report.

- **Case 2 R5 Improve the awareness of and response to domestic abuse by GP practices.**

- **Case 3 R4. Maintain a variety of means of raising awareness among the public and front line staff in rural areas of the nature of domestic abuse, and of the help available. This should include awareness that abuse includes coercion and control as well as violence.**

- **Case 2 R6 & 7 Improve hospital staff awareness of and ability to respond to domestic abuse including asking relevant patients about abuse when they attend hospital.**

- **Case 2 R8 Implement further training and initiatives to improve the response by all agencies to alcohol abuse in line with the Devon alcohol strategy**.