East Staffordshire Community Safety Partnership

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

in respect of

"May"

Autumn 2018

Independent Author: Eleanor Stobart

Completed: 18 September 2020

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CONTENTS

1. THE REVIEW PROCESS 4
1.1. Contributors to the review 4
1.2. Review Panel 4
1.3. Author of the overview report 5
1.4. Terms of reference and key lines of enquiry 5
2. SUMMARY CHRONOLOGY 6
3. KEY ISSUES, LESSONS LEARNT AND CONCLUSIONS 7
3.1. Recognising and understanding coercive control 7
3.2. Recognising and understanding economic abuse 7
3.3. Domestic abuse and the danger of separation 7
4. RECOMMENDATIONS 8

1. THE REVIEW PROCESS

This domestic homicide review was commissioned by East Staffordshire Community Safety Partnership following the death of a white British woman, 'May'. Her husband was convicted of her murder in June 2019 and sentenced in July 2019 to 18 years and 62 days' imprisonment. The review examined the contact and involvement that agencies had with May, her husband and their child between March 2017 and the time of May's death in Autumn 2018.

To protect the identity of the family members, the following anonymised terms and pseudonyms have been used throughout this review:

May – deceased aged 52 Perpetrator – husband aged 58 Child – aged pre-teen	Age at the time of May's death

1.1. Contributors to the review

The review was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) under s.9 (3) Domestic Violence, Crime and Victims Act (2004). Individual management reviews and chronologies were requested from:

- Staffordshire Police
- West Midlands Ambulance Service
- University Hospitals NHS Foundation Trust (mental health)
- General Practitioner
- Burton and District Mind
- Citizens Advice
- School

All the authors of the individual management reviews and information reports were independent of the case i.e. they were not involved in the case and had no direct management responsibility for any of the professionals involved.

1.2. Review Panel

The review panel comprised:

- Independent Chair and Author - Eleanor Stobart
- Communities, Open Spaces & Facilities Manager, East Staffordshire Borough Council - Michael Hovers
- Head of Investigations, Midlands Partnership NHS Foundation Trust - Jenny Ball
- Senior Investigating Officer, Major Organised Crime, Staffordshire Police - Detective Chief Inspector Jason Everett
- Family Liaison Officer, Staffordshire Police - DC Mark Astle
- Review Team Specialist Investigations, Staffordshire Police - Mark Harrison

- Designated Nurse for Adult Safeguarding, East Staffordshire Clinical Commissioning Group - Lisa Bates
- Divisional Director Staffordshire, Warwickshire and West Mercia, New Era Victim Services, Victim Support - Melanie Hancox
- Domestic Abuse Lead & MASH[1] Principal Officer, Staffordshire County Council - John Maddox
- Matron Safeguarding Adults University Hospitals of Derby and Burton NHS Foundation Trust - Leanne Millard

1.3. Author of the overview report

The chair and author of this review has been a freelance consultant for 20 years. She specialises in violence against women and girls, safeguarding children and vulnerable adults with a particular focus on domestic abuse and working with minority ethnic families. Eleanor is independent of, and has no connection with, any agency in Staffordshire; she has never been employed by any agency in Staffordshire. She has completed two previous domestic homicide reviews in Staffordshire but not for East Staffordshire Community Safety Partnership.

1.4. Terms of reference and key lines of enquiry

The individual management reviews were required to address both the 'generic issues' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- What knowledge or information did your agency have that indicated May might be at risk of abuse, harm or domestic violence and how did your agency respond to this information?
- If your agency had information that indicated that May might be at risk of abuse, harm or domestic violence was this information shared? If so, with which agencies or professionals?
- What knowledge or information did your agency have that indicated the perpetrator was violent, abusive or controlling and might cause harm to someone and how did your agency respond to this information?
- If your agency had information that indicated that the perpetrator was violent, abusive or controlling and might cause harm to someone, was this information shared? If so, with which agencies or professionals?
- Was there anything about their child's presentation that indicated that their child was witnessing domestic abuse or living in a household with domestic abuse? If so, how did your agency support the family?
- Were there issues of capacity or resources within your agency that had an impact on your agency's ability to provide services to May, the perpetrator or their child? Did capacity or resources have an impact on your agency's ability to work effectively with other agencies?

[1] MASH (multi-agency safeguarding hub)

2. SUMMARY CHRONOLOGY

May and the perpetrator met when they worked together in Burton. They had been married for 15 years. The house was privately owned, and both the house and the mortgage were in the perpetrator's name. He was employed at a local supermarket and May was a housewife. Their child was born in 2005 when May was 39 years old.

Before 2017, little was known by agencies about the family. Then in March 2017, May made a 999 call to the police because the perpetrator had gone missing from home. He had been experiencing some health problems, and he left home without his medication. He was found by a road worker the following day, who called an ambulance for him. His GP made an urgent referral to Midlands Partnership NHS Foundation Trust (mental health services). As the perpetrator exhibited no signs of acute mental illness, no mood disorder, depression or suicidal intent, he was signposted to the 'Together for Mental Wellbeing' service.[2]

Another 999 call was made to the police when the perpetrator went missing again on 12 August 2018. On this occasion the police classified him as a high-risk missing person. He had discovered the day before that May was having an affair. The perpetrator told May that she and their child would be better off without him and he left the house. He was found a few hours later, having attempted to take his own life by using an overdose of insulin. He was taken to the emergency department where another referral was made to Midlands Partnership NHS Foundation Trust (mental health services). He was discharged from hospital two days later to stay at his brother's house. He was visited by mental health workers at his brother's house on 16 August and seen at his home on 17 August 2018. By this time the perpetrator felt that he did not require further support and his case was closed.

Nevertheless, he telephoned Midlands Partnership NHS Foundation Trust (mental health services) on 3 September 2018. He asked to be re-referred to mental health services. He was noted to be very distressed and he wanted to speak to someone. He said he was struggling to come to terms with the end of his marriage and was having suicidal thoughts. On 4 September 2018, the Midlands Partnership NHS Foundation Trust (access team) called the perpetrator. He agreed to an appointment on 24 September and agreed to contact the access team if he needed to talk or felt at risk. During this period, the perpetrator sent the man with whom May was having an affair some abusive and threatening text messages.

Just before 10pm on an evening in Autumn 2018, Staffordshire Police received a 999 to inform them that the perpetrator had killed May by strangling her. Paramedics found May unresponsive and she was confirmed dead on arrival at hospital. The perpetrator was arrested for murder at their shared home. He was remanded in custody. In July 2019, the perpetrator was convicted and sentenced to a minimum of 18 years and 62 days' imprisonment.

[2] This service works alongside individuals as they overcome obstacles and move forward with their life. This might include (for example) managing mental health, returning to work, solving housing issues and reducing the need for mental health services – for further information see Staffordshire Connects accessed online 20 November 2019

3. KEY ISSUES, LESSONS LEARNT AND CONCLUSIONS

3.1. Recognising and understanding coercive control

There was no information within the review to show that the perpetrator was violent towards May. Nevertheless, it was clear he was controlling. Research shows that threats or attempts at suicide by a perpetrator are a clear risk factor in domestic homicide. In fact, research suggests that many domestic homicides take place in the context of "*male dominance and control which is manifested in possessiveness, extreme jealousy, attempts to isolate the women, threats of suicide, and threats to kill that are often triggered by loss of control due to impending separation or real or imagined infidelity*".[3] Indeed, the "*Controlling or coercive behaviour help guide*" developed by Staffordshire Police cites threats of suicide by the abuser as an aspect of coercive control.[4] May did not work and she could not drive, both of which contributed towards her being isolated from friends and family. Her communications appeared to be monitored and she did not have equal access the household income.

3.2. Recognising and understanding economic abuse

It is not clear whether May really understood the concept of either coercive control or economic abuse. May no longer worked and she was described as a housewife by the time of her death. She told Citizen's Advice that she received tax credit and child benefit into her account and that money paid for the gas, electric and internet bills. Whilst their house and mortgage were in her husband's name only. There were no joint bank accounts. We do not know for certain what May's experience was, but we know that perpetrators may demand to know how money is spent and make a victim continually ask for money. They may refuse to contribute to the household bills whilst spending money on other things and building up debt for the victim. It was clear from May's conversation with Citizen's Advice and from the chair's discussion with the perpetrator that May did not have access to money or enough money to leave.

3.3. Domestic abuse and the danger of separation

The perpetrator's coercive controlling behaviour and the economic abuse that May suffered made her more vulnerable, especially when she decided to end her relationship with him. Leaving an abusive partner can be very dangerous. Research[5] shows that women are at greater risk of violence and being killed after separating from abusive partners.

Mental health services, the GP Practice and staff at the emergency department were aware that the marriage had broken down. During this period, the focus of

[3] See for example, Johnson H et al, Intimate femicide: The role of coercive control, Feminist Criminology (2017) – accessed online 20 November 2019

[4] Controlling or coercive behaviour help guide: We're on your side, Staffordshire Police – accessed online 20 November 2019

[5] See for example Refuge Website: Forms of violence and abuse - barriers to leaving; www.womensaid.org.uk/domestic-violence-articles.asp?section=00010001002200020001&itemid=1126 and www.femicidecensus.org.uk The Femicide Census; 2017 Findings – accessed online 20 November 2019

health professionals was always on the perpetrator and his deteriorating mental health, rather than the risk he may pose to May and their child.

4. RECOMMENDATIONS

i. East Staffordshire Community Safety Partnership should write to the Executive Director of Operations at Citizens Advice (enclosing a copy of the final report) to ask her to review whether their advisors receive appropriate training on domestic abuse (including information on coercive control and economic abuse).

ii. Midlands Partnership NHS Foundation Trust should evidence that clinical staff are adhering to the Carer Engagement Standards as well as the "Our Service User and Carer Charter".

iii. Reassurance should be sought by Staffordshire Police that 'prevention interviews' following missing persons episodes consider safeguarding measures and referrals to appropriate services.

iv. It should be standard practice that as soon as the threshold for a domestic homicide review is met, a letter should be sent on behalf of the independent chair to request access to the perpetrator's medical records.

v. The adult safeguarding training delivered by the Clinical Commissioning Group to primary care staff on domestic abuse should include coercion and control. This should be evidenced by research findings such as 'Counting Dead Women' and 'Partner Femicide.

vi. The GP Practice should seek additional support and training on domestic abuse, and it should include the signs of coercive control. This will ensure that the staff are aware of their duties to explore and document discussion following disclosures such as marital breakdown.

vii. The Domestic Abuse and Commissioning Development Board (DACDB) should seek assurance that training and development in relation to domestic abuse for GPs is meeting its objectives. The specific areas of development include coercion and control, escalation of risk linked to recent studies around the preceding steps to domestic homicide.

viii. The Domestic Abuse Commissioning and Development Board should assure the East Staffordshire CSP that awareness of domestic abuse (especially coercion & control and economic abuse) is being enhanced across a wide landscape of agencies particularly the Voluntary, Community and Social Enterprise (VCSE) community. This should further safeguard their service users and the public, in line with the findings of this review.