SUFFOLK COASTAL
COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Into the death of
Emma in June 2014

Report Author

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DOMESTIC HOMICIDE REVIEW

Preface

Before introducing this Domestic Homicide Overview Report, the Suffolk Coastal Domestic Homicide Review Panel would like to express their sympathy to the family of all those involved in this tragic event. We would like to send our sincere condolences to the victim's family and friends for the loss of a much loved mother, daughter, friend and colleague. We would also like to recognise the emotional distress experienced by the perpetrator's family members, and his former friends which has been caused by his actions.

The independent chair and author of the Review is particularly grateful for the help and contributions which have been given by family members especially when they had to deal with continuing legal matters arising from the criminal events and the trial. The author wishes to thank the friends and work colleague who have contributed to this Review once the criminal trial was over. Thanks are also due to the Panel for their time and thoughtful deliberations which have contributed to the findings of this Review.

This report of a Domestic Homicide Review (DHR) seeks to examine any agency contact with the victim and perpetrator who were residents of the Suffolk Coastal Community Safety Partnership area prior to the time of the victim's death in June 2014.

This Review was commissioned by the Suffolk Coastal Community Safety Partnership following notification of the victim's death in circumstances which appeared to fulfil the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004, namely the homicide appeared to be by a person to whom the victim was related, or with whom they had, or had been in an intimate relationship. The Home Office defines domestic violence as:

> *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, and 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*

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand 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 term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

1. Introduction

Summary of Circumstances Leading to Review

1.1 One evening in June 2014 the Police were called by a member of the public to the victim's home. The victim's children had returned home with their paternal grandmother and were unable to gain entry to the house. The Police attended the address and on gaining entry the body of the victim was found.

1.2 Earlier the same evening the Police received a call from the Ambulance Service reporting that they were attending a male who had slit his wrists and he was being difficult to engage. The Police joined the ambulance team to assist and the male was taken to hospital for treatment. He was the former partner of the victim. He was arrested at the hospital on suspicion of the murder. During transportation to the Police Investigation Centre the perpetrator made significant comments admitting that he was responsible for the victim's death. The perpetrator was found guilty of murder in December 2014. He was sentenced to serve a minimum of 22 years.

Timescales

1.3 The Suffolk Coastal Community Safety Partnership was notified of the homicide in June 2014. The decision to hold a DHR was made by the Community Safety Partnership chair in consultation with the Partnership members on 15 July 2014. This was in line with statutory guidance. The Home Office was notified of the Partnership's decision to undertake a DHR on 7 August 2014. The Review was concluded on 29 June 2015. It was not possible to complete the Review within 6 months as required by statute due to the timescale of the criminal proceedings which did not conclude until December 2014. Following this date the Review process recommenced. The Home Office was informed of this delay.

1.4 Confidentiality

1.5 The findings of this Review are held to be confidential, with information available only to participating officers/professionals and their line managers until the Review has been approved for publication by the Home Office Quality Assurance Panel.

1.6 To protect the identity of the victim, perpetrator, and their family members the following pseudonyms have been used throughout this report:

The victim: Emma, age 39 years at the time of her death
The perpetrator: Gary, age 42 years at the time of the homicide.

Both Emma and Gary were of White British ethnicity

1.7 To protect the identity of the children in the family their details are being withheld from the Review report.

Dissemination

1.8 The following will receive copies of this report:

Chair of Suffolk Coastal Community Safety Partnership & Board Members
Suffolk Police & Crime Commissioner
Chief Constable, Suffolk Constabulary

Chair Ipswich & East Suffolk Clinical Commissioning Group
NHS England for the Eastern Region
Chief Executive, Norfolk & Suffolk NHS Trust
Director of Children's Services, Suffolk County Council
Chair Suffolk Health & Wellbeing Board
Suffolk Adult Safeguarding Adult Board
Suffolk Local Children's Safeguarding Board
GP Practices involved in the Review
Named GP for West Suffolk CCG and Ipswich and East Suffolk CCG
The victim's close family members

Terms of reference of the Review

1.9 **Statutory Guidance states the purpose of the 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 policies and procedures as appropriate; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- To seek to establish whether the events leading to the homicide could have been predicted or prevented.

This Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for the coroner and the criminal court.

1.10 **Specific Terms of Reference for this Review:**

1. To establish the history of the victim and alleged perpetrator's relationship and provide a chronology of relevant agency contact with them, the children of the family, and the parents of the victim and alleged perpetrator. The time period to be examined in detail is between January 2014 and June 2014, the date of the couple's final separation and the victim's death. Agencies with knowledge of the victim and alleged perpetrator in the years preceding this timescale are to provide a brief summary of that involvement. Any interaction with family members or friends which has relevance to the scope of this review should also be included.

2. To examine whether there were signs or behaviours exhibited by the perpetrator in his contact with services which could have indicated he was a risk to the victim or others.

3. Agencies reporting involvement with the victim and the alleged perpetrator to assess whether the services provided offered appropriate interventions and resources, including communication materials. Assessment should include analysis of any organisational and/or frontline practice level factors impacted upon service

delivery, and the effectiveness of single and inter-agency communication and information sharing both verbal and written.

4. To assess whether agencies have domestic abuse policies and procedures in place, whether these were known and understood by staff, are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

5. To examine the level of domestic abuse training undertaken by staff who had contact with the victim and/or the alleged perpetrator, and their knowledge of indicators of domestic abuse, both for a victim and for a potential perpetrator of abuse; the application and use of the DASH[1] risk assessment tool; safety planning; referral pathway to Multi Agency Risk Assessment Conference (MARAC)[2], and to appropriate specialist domestic abuse services.

6. To determine if there were any barriers which may have affected the victim's ability to disclose abuse or to seeking advice and support.

7. In liaison with the Police Family Liaison Officer the chair/author to contact family, friends, and colleagues to invite their contributions to the Review and, whilst acknowledging the pitfalls of hindsight, seek their views as to whether anything needs to change to reduce the risk of similar events in future.

Methodology

1.11 Following notification of the homicide to the Community Safety Partnership contact was made with local statutory and voluntary agencies to establish whether they had contact with the victim, perpetrator or family members. A total of 13 agencies were contacted in addition to checks with the Local Safeguarding Children's Board and Suffolk Adult Safeguarding Board. 7 agencies reported no involvement and 6 confirmed some form of contact with the parties involved in this Review. The notification also requested that agencies secure their files if contact was confirmed.

1.12 Contact with agencies was found to be minimal, with the only chronologies of contact arising from GP practices and hospital appointments. The victim's contact with these health agencies was limited, routine, and no issues arose to indicate that the victim may be experiencing domestic abuse or coercive control to the extent that Individual Management Reviews were deemed unnecessary.

1.13 The perpetrator's health records showed contact with Mental Health Services outside the timescale under review and a brief intervention within the time for review at the time of his arrest. The service consulted has provided a chronology and proportionate report which addresses the terms of reference for this review. GP practices for both parties provided answers to additional questions to augment their chronologies.

1.14 Information from records used in this Review were accessed in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purpose of the

[1] Domestic Abuse Stalking & Harassment (DASH): an evidence based list of 24 or 27 questions used to assess the level of risk a victim faces – standard, medium or high. High risk indicates referral to MARAC is needed. The threshold for MARAC referral is 14 or above positive answers to the DASH questions.

[2] MARAC a multi-agency meeting to share information to safety plan and allocate actions with the aim of increasing the safety of high risk victims of domestic abuse.

Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables data to be transferred if it is necessary for the purpose of the prevention or detection of crime, or the apprehension and prosecution of offenders. The purpose of this Domestic Homicide Review is to prevent other similar crimes.

1.15 Terms of Reference for the Review were agreed by the DHR Panel and these were shared with the victim's parents and eldest child. This was done following liaison regarding a suitable time with the Police family liaison officer, the Victim Support Homicide Team support worker, and the children's social worker who were supporting the family. The victim's family members were in agreement with the questions raised within the terms of reference and did not wish to add any further items. The final draft of the Overview report was shared with the victim's parents and they agreed with its findings and recommendations; they did not feel it necessary to add anything further themselves.

1.16 In gathering information for the Review the author held face to face interviews with the parents of the victim and the perpetrator's parent. Seven letters inviting contributions to the Review were written to friends or colleagues and from these two face to face interviews took place with friends/colleagues of the victim, one of the perpetrator's friends, and one telephone interview took place with another of the perpetrator's former friends. All letters were accompanied by the appropriate Home Office leaflet explaining about Domestic Homicide Reviews.

1.17 In addition to interviews the author has been greatly assisted in gaining a picture of the couple's relationship during the period set in the terms of reference by having access to Police statements for two individuals who felt unable to take part via interview.

1.18 The author emailed the director with responsibility for Human Resources at the company where the victim worked attaching the DHR leaflet for employers. The email enquired whether the company had a domestic abuse policy or any staff notices concerning sources of help. The company was offered sources for publicity materials and policy examples if required. No response was received from the company to this approach.

1.19 The Department of Work & Pensions (DWP) was contacted for information. However, the Panel was advised that as they are not named as a contributing agency with statutory responsibility for cooperating with a DHR their legal advice prevented them from providing data. During interviews for the Review the author was given salient information concerning the perpetrator's use of untrue information to retain benefits and the DWP was approached again with a request for the minimal information which could corroborate this and which is helpful in throwing light on the perpetrator's character. No response was received to this request.

1.20 The author contacted the prison supervisor responsible for the perpetrator to inform them of the Review and that a letter inviting his contribution would be sent. This was agreed. However, on contacting the prison two weeks later the prison service advised that this invitation would not be suitable at that time and therefore recommended that he not be contacted.

1.21 The author is most grateful to the family and friends who have contributed to this Review, and to the Police for their assistance with transcripts of interviews.

Contributors to the Review

1.22 Those contributing to this Review do so under Section 2(4) of the statutory guidance[3] for the conduct of DHRs and it is the duty of any person or body participating in the Review to have regard for the guidance. However, it must be noted that whilst a person or organisational body can be directed to participate, the chair and DHR Panel do not have the power or legal sanction to compel their cooperation or to attend the Panel for interview.

The following agencies contributing and the method of their contributions are :

- Norfolk & Suffolk Foundation NHS Trust (Mental Health Services) – chronology & report
- GP Practice (for perpetrator) – Chronology and additional information
- GP Practice (for victim) – Chronology and additional information
- Ipswich Hospital NHS Trust – Chronology
- Suffolk Constabulary - information relating to the investigation
- Suffolk County Council Children's Services – Information and information from schools

The Review Panel

1.23 The members of the DHR panel conducting this Review were:

Name of Panel Member	Role or Job Title	Agency
Stuart McCallum	Detective Chief Inspector	Suffolk Police
Tash Nicholson	Patient Safety & Complaints Practitioner	Norfolk and Suffolk NHS Foundation Trust
Roy Elmer	Safeguarding Adult Board Manager	Suffolk County Council
Shirley Osborne	Domestic Abuse Lead	Suffolk County Council
Karen Hubbard	Community Development & Community Safety Manager	Suffolk Coastal District Council
Julia Catterwell	Community Safety Officer	Suffolk Coastal District Council
Sally Winston	Chief Executive	Lighthouse Women's Aid
Tina Wilson	Head of Safeguarding and Reviewing Officer Service	Children & Young People's Services Suffolk County Council
Gaynor Mears	Independent Chair & DHR Author	

The Author

1.24 The author of this DHR Overview Report is independent consultant Gaynor Mears OBE. The author holds a Masters Degree in Professional Child Care Practice (Child Protection); her MA dissertation focussed on the coordination of domestic abuse services; she also holds an Advanced Award in Social Work in addition to a Diploma in Social Work qualification. The author has extensive experience of working in the

[3] Home Office (2013) *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews - Revised*

domestic abuse field both in practice and strategically, including roles at county and regional levels. Gaynor Mears has undertaken previous Domestic Homicide Reviews, and research and evaluations into domestic violence services and best practice. She has experience of working in crime reduction in a management role, with Community Safety Partnerships, and across a wide variety of agencies and partnerships. Gaynor Mears is independent of, and has had no connection with, any agencies in Suffolk or the Suffolk Coastal Partnership area in the past or currently.

Parallel Reviews

1.25 A Coroner's inquest was opened and adjourned. The Coroner for the area was formally notified of the DHR by letter from the independent chair on 13 November 2014. Family court proceedings took place following the conclusion of the criminal trial.

2. The Facts

2.1 Emma and Gary were residents of the Suffolk Coastal area in the county of Suffolk. Emma and Gary were of white British ethnicity, although Emma had dual American and British citizenship. Apart from a short period of living with a relative in the United States in her mid-teens Emma she was a permanent resident of Suffolk as was Gary. It was in the Suffolk Coastal area that the murder took place in June 2014.

2.2 The couple had been in a relationship for approximately 25 years. During that time there had been separations, and the couple did not always live together full time even when their relationship was going well. However, in late 2013 early 2014 the relationship appears to have become strained once more and by May 2014 a more permanent separation took place. This appears to have been acrimonious as Gary assaulted Emma during an argument at her place of work on 22 May 2014. This was not reported to any agency at the time and came to light during the Police investigation.

2.3 According to Emma's parents it was revealed during the criminal trial that Gary still had a key to Emma's home, and they report that a neighbour saw him sitting in his car near the property a few days before the fatal incident. On the day of the murder the children's paternal grandmother arrived at the house to return the children home to Emma after they had been visiting her, but was unable to enter the house. A neighbour telephoned the Police and officers attended and forced entry. Emma's body was found in the lounge area.

2.4 Earlier the same evening the Police had received a call from the Ambulance Service who were attending Gary's address to tend a man who had slit his wrists. He was refusing to engage with the Police and ambulance crew at the scene, and he had cuts to his body. Gary was taken to hospital for treatment and a mental health assessment. Police arrested Gary at the hospital on suspicion of Emma's murder. He was taken to the Police Investigation Centre and during the journey he admitted killing Emma and said he had intended to take his own life. He was charged with murder and remanded in custody. At the conclusion of his trial Gary was found guilty of murder and was sentenced to a term of 22 years' imprisonment.

2.5 The post mortem examination carried out by the Home Office pathologist found that Emma's death was caused by significant blunt force head trauma.

2.6 At the time of the fatal incident Emma lived in a house she rented from her parents who lived in the United States. The household consisted of Emma and her children who were all of school age.

2.7 None of the adults in this Review were considered to be 'vulnerable adults' as defined by the Department of Health 'No Secrets' guidance, nor were they considered an 'adult at risk' which has replaced the term 'vulnerable adult' in Section 14 of the Care Act 2014. As a consequence they did not require and were not eligible for community services. There were no Safeguarding children's services involved other than in the period following the murder when the children received support under a Children in Need plan.

2.8 There are no discernible equality or diversity issues affecting the victim or the perpetrator in this review. All members of the family were White British ethnicity and there is no evidence to suggest that either Emma or Gary experienced any difficulty in accessing services. Gary had been referred by his GP to mental health services in the past which he accessed and he was offered counselling and referral to Drug and Alcohol Services for his heaving cannabis use. However, there is no evidence that he accessed services for his dependence on cannabis.

3. Chronology

Background Information

3.1 Emma was born in the Midlands and moved to the Suffolk Coastal area with her family when she was very young. Gary was born and brought up in the Suffolk Coastal area in Suffolk. The area has a population of 124,600 and is mainly rural with picturesque villages and small market towns in which 80% of the population live[4]. The unemployed population in receipt of Job Seekers Allowance in the 25 to 49 years age range (which encompasses Gary's age cohort) in the year to March 2015 was low at 0.1%[5]. Suffolk Coastal is a low crime area; and the district in that area in which Emma lived was the second lowest for 'violence against the person' crimes with 127 recorded in the year to March 2015, compared with a more urban area in the Suffolk Coastal area of 338 for the same period.

3.2 Emma and Gary lived in villages in the Suffolk Coastal area. Emma's parents recall that she first met Gary when she was 14 years old and he was 17 years old. Their friendship is thought to have started the following year. In 1990 Emma went to the United States as her parents intended to move there, but their plans changed and Emma stayed for 6 months and then returned to Suffolk to finish her education. After school she joined a local company where she worked continuously until her death apart from maternity leave to have her children. She worked Monday to Thursday part time to fit in with school hours. Emma's skills and attention to detail lead to her working on the more intricate products produced by the company.

3.3 Emma's childhood friend and a long term colleague and friend with whom she worked and socialised describe her as being a really kind and non-judgemental person who would not say a bad word about anyone. She was a big animal lover and she had cats and two dogs all of which had been rescued. Emma worked hard, but above everyone who knew her said her thoughts were always for her children.

[4] http://www.suffolkcoastal.gov.uk/yourcouncil/sharedservices/councilprofiles/

[5] http://www.nomisweb.co.uk

3.4 Apart from complaining about Gary never having any money, Emma did not speak about her relationship with him to her friends. Their socialising was always just with Emma, they felt that Gary was anti-social and not very confident and he did not like sharing Emma with others. One of her close friends recalls bumping into Emma in a supermarket and not having seen her for a few months she was pleased to see her and stopped to talk, but Gary scowled and rolled his eyes and said they had to go. Emma then said that she had better go as he was getting cross. Gary could also be possessive of his own small group of close male friends. One related how if other friends came round to see him Gary would leave rather than join in.

3.5 Gary is described by his mother as having been a quiet affectionate boy and even as he grew older he would show affection to her in front of his friends. He was popular when young, but as a teenager he is described as being complex and in the intervening years he became less sociable and introverted. He went into the army on leaving school, but only completed basic training and after 6-9 months he bought himself out. He told a long term friend that he did not like the discipline or the other trainee soldiers.

3.6 Gary had a variety of jobs after this, but was made redundant on four occasions. One of his oldest friends reports that when they were at school Gary was into skateboarding and Hammer House of Horror films. This interest in horror films continued and two of his former friends recall that they were disturbed by the extreme nature and violence of some of the films in his extensive film collection. Gary once brought a film to show to the friends one of whom reported that they were really shocked by the content, but they saw first-hand how Gary became very excited watching it. Friends report that Gary was obsessed with his film collection, and he would buy and sell the films on eBay. On the other hand he also had a collection of old television comedy series such as the Good Life, Porridge and Dad's Army. One friend recalled that despite his propensity for violent films, he did not like realistic modern day gangster type films.

3.7 In 1993 Emma and Gary began living together in a flat locally, and in 1998 their first child was born. Two years later they separated and Emma returned to her parent's home to live and Gary remained in the flat on his own. It was around this time (2000) that Emma had a termination of pregnancy, and Gary was treated for depression by his GP. A friend recalled that Gary drank very heavily for about a year after the separation, frequently drinking all day until he passed out, but then he just stopped and decided to get himself fit. Friends report that Gary was a heavy user of cannabis which he smoked daily, and he had also used 'speed' and other substance on occasions. He is reported to have frequently driven whilst under the influence of drugs.

3.8 On 31 January 2001 Gary was referred by his GP to a local Psychiatrist as his depression was proving resistant to treatment. He was seen for assessment on 8 March 2001 by Psychiatrist 1. There followed bi-monthly appointments with Psychiatrist 2 until October 2001 during which he was advised to attend counselling, to continue with anti-depressants, and to reduce his cannabis and alcohol use. He was given the contact details of the Community Drugs Team and his GP was advised to refer him to NORCAS drug treatment service. The records within the report from the Norfolk & Suffolk NHS Foundation Trust show that little change could be achieved as Gary was not motivated to change his habits concerning cannabis and alcohol, and not motivated to see employment. He had a pre-morbid personality[6].

[6] Pre-morbid personality describes personality traits existing prior to illness or injury. Encyclopaedia of Clinical Neuropsychology http://link.springer.com/referenceworkentry/10.1007%2F978-0-387-79948-3_2056 's

3.9 The history of Emma and Gary's relationship consisted of periods of being in a relationship and then splitting up; the couple never married and although they were in an on-off relationship for 25 years for the approximately the last 10 years they did not fully live together in the same home. Those who knew the couple well report that Gary never wanted children and he was very unhappy when Emma became pregnant and some contributors felt that Gary just wanted Emma to himself. When Emma became pregnant she had not told Gary that she was not using contraception. A long term friend reports that Gary told him he felt trapped by Emma and had no say, but equally if they had a disagreement Gary would leave rather than discuss things with Emma to the extent that he left the family at Christmas on at least one occasion and spent it on his own.

3.10 On 12 March 2002 Gary was seen on in a Medical Assessment Unit by Psychiatrist 2 following an intentional overdose having taken a relatively small dose of aspirin and alcohol. He had apparently split up with Emma once more (having woken her to tell her that he had taken an overdose). He had also stopped taking his anti-depressants, his benefits had been stopped and he was in debt. Gary's GP requested an urgent assessment and Gary was seen by Psychiatrist 2 on 22 March 2002. In a letter to his GP Psychiatrist 2 noted no real change in Gary's lifestyle including a reduction in his drug and alcohol use and no motivation for change. There were no further suicidal thoughts and his anti-depressants were to continue. A further outpatient appointment was sent, but Gary failed to attend. Psychiatrist 2 described the suicide attempt as manipulative in as much as it followed Emma's attempts to end the relationship and he had woken her to tell her of the attempt. He also asked the Psychiatrist to contact the Department of Work and Pensions on his behalf to tell them he was unfit to work and to request that his benefits be reinstated.

3.11 Gary once moaned to his friends about his benefits being cut because he had not reported to the job centre. Two friends recalled how he came up with a plan to deal with this. He went to the benefit office and said his sister had died and he missed his appointment due to the funeral and other arrangements. His benefit was reinstated. Gary does not have a sister, but no checks appear to have been made to confirm this. The friend described how Gary laughed that he had regained his benefits this way and said "they're dumb aren't they".

3.12 A former friend also described how Gary took out a bank loan for £15,000. He then went to the Citizen's Advice Bureau saying the bank had given him a loan he could not afford to pay back; he achieved a reduced payment plan of a £1 a month. Gary is reported to have told the friend that he had put the money in a bank account in one of his children's names to which he had access so that his benefits would not be affected. One former friend described Gary as a scrounger who knew how to work the system.

3.13 In late 2009 Gary's father died which affected him badly. In January 2010 he felt mildly suicidal and was treated for problems with sleeping and low mood by his GP and given a sick note for 4 weeks. He continued to be seen by his GP in February and March and his home situation was noted in that he lived with his mother and his ex-partner and children lived in another village. As Gary's mood continued to be fairly flat in April he was referred to the IAPT[7] Team for support and seen by a Community Psychiatric Nurse in June 2010. He was advised to access counselling and treatment was commenced with Mirtazapine to which he responded well. Cannabis use and occasional alcohol was noted and that he was separated from his partner.

[7] Improving Access to Psychological Therapies programme.

3.14 On 29 March 2010 one of Emma's children was seen at the hospital for a hearing assessment. The child's school had reported that they were 'challenging' and highlighted their difficulty in maintaining attention to tasks and complying with instructions. The hearing test was undertaken at Emma's behest as she questioned whether a hearing problem could possibly be behind the behaviour, but following an assessment no hearing problem was found. The school was not informed about the hearing test or its outcome.

3.15 Gary saw his GP in January 2011 and reported that he was feeling much better. He was keeping himself occupied, looking for work and that he was on good terms with his ex-partner and children. He was more animated and with better eye contact.

3.16 When his GP saw him next in August 2011 Gary said he was spending half his time with his mother and that he was trying to get back together with his former partner. He appeared to be much more animated than on previous occasions and very stable. The plan was to have a review in early 2012. At the review in April 2012 Gary reported feeling a little flat in mood although he was feeling physically good. He said he was continuing to do things with his children. The plan was to wean him off Mirtazapine with the aim of trying Venlafaxine as an alternative. Gary later phoned his GP and said he wished to remain on Mirtazapine. Appointments during 2013 were for minor ailments and of no relevance to this Review.

Chronology from January 2014 to June 2014

3.17 Information from a Police statement provided by a close family member indicates that Emma and Gary's relationship ceased from January 2014. Prior to that date Gary would 'sleep over' at Emma's house three or four times a week, and by 'sleeping over' the family member reported that Gary slept on the couch in the lounge. The family member reported that there were constant arguments in which Gary would bring things up from the past, but Emma just wanted him to 'get on with it'. It is understood that Emma gave Gary an ultimatum to get a job, to stop taking drugs and to sort his life out; she gave him a year to achieve this. This is borne out Gary's friends interviewed for this Review who were aware that of the ultimatum to get a job and to 'do his bit with the children'. One former friend related how Gary said "that bloody bitch wants me to get a job" and on a separate occasion Gary said "I'm fed up, she wants me to get a job, but I don't want to". By this time Gary had been unemployed and in receipt of benefits for at least 8 years.

3.18 Gary and Emma had separate GPs as they lived in different villages. During this period of time Gary saw his GP twice in connection with pain in his elbow and foot, once on 5 February when it was noted that his mood was good with Mitazapine and it was planned the he should continue to take this medication. He was seen again on 12 March 2014 and on this occasion he also sought help with giving up smoking. The GP chronology comments that he seemed very well from the mental health viewpoint at this last clinic visit; he had been stable for some time using Mirtazapine as an antidepressant.

3.19 Emma saw her GP on two occasions during this period of time; firstly on 19 February 2014 for the treatment of a cough which was causing her lower back pain for which she was advised about back exercises and antihistamines. Secondly on 6 May 2014 when she was prescribed Naproxen an anti-inflammatory medication. These GP appointments are the only contact with a service by Emma and Gary in the 6 months leading up to the fatal incident.

3.20 On 22 May 2014 Gary went to Emma's place of work and an argument took place between them. Gary wanted more time to change, but Emma had decided that she

had had enough and no longer wanted to be in the relationship. Police statements about the incident taken during the murder inquiry report that Gary grabbed Emma around her throat and pushed her into bushes. Some work colleagues came running out on hearing her screams and Gary jumped into his car and drove away. Sometime later a long term friend reports that Gary phoned him saying he had assaulted Emma; he had his passport, he was in a local wood and could not go home because the Police would be looking for him. He wanted his friend to collect him, but his friend was at work. The friend recalls that Gary had no appreciation that he was at work and could not drop everything to go to him. He also phoned another friend about this incident. The Police were not in fact called about this assault.

3.21 As a result of the assault Emma had bruising and a small cut to her shoulder. A childhood friend who went out with her that evening described how Emma looked pale and tired and she seemed to lack confidence; she said 'perhaps people aren't interested in me'. Her friend reports noticing a mark on Emma's neck and then Emma told her about the attack by Gary and showed her scratches on her arms from falling into bushes and finger grip marks on the top of her arm. Emma said she did not want anyone to report it; she did not want a big deal made of it. Her friend told the Review author that she did as Emma asked as she did not want to betray her trust in case Emma did not trust her again and their friendship was affected. Her friend was aware that a work colleague had seen the assault, but Emma had also insisted that she did not report it.

3.22 Following this event and Emma telling Gary she no longer wanted to be in a relationship with him, the family member's statement reports that Gary texted Emma regularly wanting to get back together saying he was sorry, that he was getting money together, and was on a few jobs. On Thursday 29 May 2014 Gary sent a long text in which he said he was going to commit suicide. Emma refused to take any of Gary's telephone calls and at one stage threatened that she would block him from being able to get through to her phone. On 2 June 2014 Gary called round to Emma's home while she was at work. He spoke to his eldest child and said he had been to the woods to look for a suitable tree to hang himself. Gary was also texting his eldest child at this time asking that they help him get back with Emma.

3.23 One day at the beginning of June 2014 Gary took his eldest child to the cinema and whilst they were out together he said that he was in touch with the spirits of his dead father and grandfather and they had told him that Emma was using an internet dating website and was going to meet someone; she was going to move on and be with somebody else. Gary added that if he did not get back with Emma the spirits said something bad was going to happen. His eldest child thought he was saying these things because he had not eaten and was possibly high on drugs. During this outing Emma texted the child and asked that they get the back door key back from Gary, but he kept saying he did not have it and that it must be at his home. He also told the child to keep an eye on Emma and let him know if she went out with anyone.

3.24 During the first week of June Gary went to Emma's home on three occasions when she was not in, but the eldest child was there and saw him go into Emma's room and go through her things including her diary. He quizzed the child about a day in the diary marked 'today's the day'. It was reported in the Police statement that Gary had a habit of going through Emma's things including her phone during their relationship and he would challenge her about messaging friends. He seemed paranoid that she was going to meet someone else. In early June Emma blocked the receipt of calls and texts to her phone from Gary.

3.25 From the Police enquiry it is known that on the afternoon of the murder in June 2014 Gary was discovered by his mother and eldest child to have slit his wrists. He was found in the annex in which he lived at his mother's home. His child managed to remove the knife and throw it away outside, but Gary locked himself in. His mother called an ambulance and the Police also attended at 6.36pm and eventually Gary accepted treatment and was taken to hospital.

3.26 The eldest child was concerned as they had not been able to reach Emma by phone or text since late that morning which was very unusual. On reaching Emma's home the door was locked and no one answered the door. They turned to a neighbour for help and the Police were called at approximately 8.55pm. Police attended and forced entry and Emma's body was found.

3.27 Gary was arrested at Ipswich Hospital and taken to the Police Investigation Centre. Enroute and prior to formal detention in a cell he made a number of significant comments admitting responsibility for Emma's murder. He was charged with murder and held in custody.

3.28 The post mortem examination gave the cause of Emma's death as significant blunt force head trauma.

3.29 At his trial Gary pleaded guilty to manslaughter on the grounds of diminished responsibility. However, the prosecution argued that evidence provided to the court that he had purchased items used in the crime some days before showed that he had planned the murder. The plea of diminished responsibility was not accepted and Gary was found guilty of murder and given a minimum sentence of 22 years.

3.30 Neither Gary nor Emma have any prior record of contact with the Police nor did they have a criminal record. Police databases show no calls for service to the Police from either Emma or Gary at any of their addresses, and there were no reports to the Police of any domestic abuse incidents.

4. Overview

4.1 Emma's parents report that she was someone who did not like to ask for help, they did not think that she was frightened of Gary, and her friends saw no sign of this. Emma was bright and loving, she loved her children and cared greatly for her animals. She like clothes and colour, and appear happy and fun-loving; she always put on a good face in public. Emma liked to keep fit and she encouraged her children in their activities. Although they lived separately Emma and Gary would often take the children out to the cinema at weekends, but friends say they never socialised as a couple with friends; it was as if he was a single man.

4.2 Emma was very meticulous and organised. She had bought a Father's Day card ready for the children to give to Gary on that day which was just 2 days after she was killed by him; he was never known to buy her flowers or treats. Emma kept a diary and a calendar containing the family's appointments, activities, and budgeting information. It appears clear that Emma viewed the start of the New Year as a new start. Her 2014 diary started with "NEW YEAR NEW LIFE!!!" and "NEW YEAR NEW ME!!" at the top of the first two pages in large capital letters. She had written "40" in bold blue numbers on the date of her birthday. She had also written "I want to enjoy my life, not just coasting…I work hard…I've not been good to myself". As if to emphasize this Emma had changed her hairstyle, started changing her diet and was exercising regularly.

4.3 Gary is said to be a loner who has been described by one former friend as "a very dark person" and as someone who did not seem to care about people. He had what contributors to this Review have called the weirdest and most violent film collection some of which they described as 'snuff movies'. A friend reported that he specialised in buying and selling this type of video, sometimes making substantial profits. He is described as an intelligent man, who had a very good memory for facts and figures, but he had no ambition and was basically lazy; he did just enough to give him money for basics and his films. He could be brusque in manner, was not very sociable and this became worse over the years. He appears to have had a very small group of friends all of whom he had known for a considerable time

4.4 Gary did see his children on a weekly basis and he would sometimes collect them from school and they would stay at their paternal grandmother's home where he lived in an annex.

4.5 Friends recalled two separate occasions when Gary talked about 'getting rid' of Emma. On one occasion he sounded serious when he said he was "going to get rid of her one day", but the friends said they thought it was just a threat that anyone frustrated by another's actions might say. On a second occasion Gary told one of the friends that he had been up all night thinking of getting a boat, chopping Emma up and dumping her in the sea. His mood then changed and he cheered up. When he was away from this mood he was described as okay. All his friends and Emma and his eldest child knew Gary smoked cannabis daily which he had done for many years.

4.6 Emma never mentioned to friends or family that Gary was violent during their relationship, but friends who knew him had seen him get very angry; one described him as looking very scary when he lost his temper. He was known however, to put Emma down verbally and behave in a possessive manner. He could also be possessive of his friendships. In one statement to the Police there is mention that during their relationship Gary would check Emma's phone for text messages and challenge her about who she was contacting, especially when it was a male with whom Emma had been friends for many years.

4.7 Gary told a former friend that Emma had informed him if he did not get a job and do more with the children she was going to join an online dating website. He had worked out her password and accessed her computer history and use of websites, and he thought that she was going to meet someone. Close friends thought Gary believed that as they had split up so many times before it would never happen for good. Gary thought that Emma was due to meet someone the evening of the day she was killed by Gary. He had said to a friend the he would not have any other man bringing up his children, and although he said he would kill Emma his friends never believed it.

Summary of information known to the agencies and professionals involved about the victim, the perpetrator and their families

4.8 Emma saw her GP for pregnancy care and a variety of minor health issues none of which raised concerns or indicated that domestic abuse may be an issue. Her hospital attendances were when she gave birth and no issues arose anti-natally or post natally. There are no reasons given on her notes for the request for a termination in 2000, other than she was on oral contraception and had repeated prescriptions. She may have had a mishap and become pregnant by mistake on this occasion, but it was also around this time that the couple separated (see paragraph 3.7)

4.9 The children in the family had routine contact with Health for immunisations, developmental checks, or health advice. One child was seen at Ipswich Hospital in 2010 as an outpatient by the Ophthalmology Department for a hearing check following concerns about their lack of attention in school and their disruptive behaviour, but no hearing problems were found. The hearing test was arranged at Emma's request to rule out a hearing problem as the cause for the child's behaviour. Further information regarding these behaviours was sought from the school to delve deeper into the background and outcome of their concerns, but no detailed records could be found other than the content of two end of year school reports to parents. It is therefore unknown as to whether the school checked with Emma regarding any anxieties the child may have at home or other reasons to explain their difficulties. Emma had not informed the school of the hearing assessment and the results.

4.10 Gary's GP was aware of his long term depression and the treatment he had received and was still receiving for this. It was their observation that his mental health was actually much improved during the first six months of 2014 and they had no concerns that he posed a risk to himself or others, and this had been the opinion of mental health professionals who had seen him in the past in 2001, 2002 and in 2010.

4.11 None of the contributing agencies to this Review had any knowledge or information to raise any suspicion of domestic abuse within the relationship.

5. Analysis

5.1. Each of the specific terms of reference for this review will be analysed here.

1. To establish the history of the victim and alleged perpetrator's relationship and provide a chronology of relevant agency contact with them, the children of the family, and the parents of the victim and alleged perpetrator. The time period to be examined in detail is between January 2014 and June 2014 the date of the victim's death. Agencies with knowledge of the victim and alleged perpetrator in the years preceding this timescale are to provide a brief summary of that involvement. Any interaction with family members or friends which has relevance to the scope of this review should also be included.

5.2. The chronology has been addressed in section 3 of this report and will not be repeated here. However, it is appropriate to acknowledge that due to the very limited contact with agencies in this case the most illuminating information in this Review which helps in examining how and why events occurred have come from the family, friends and colleague of the victim and perpetrator, Emma and Gary. Thanks to their contributions we can attempt to gain a partial picture of their relationship which spanned 25 sometimes tumultuous years.

5.3. It is clear that Gary's lack of motivation and willingness to find employment and his heavy cannabis use played a large part in the frequent breakdowns in their relationship. There is also evidence that he was insecure about their relationship and checked up on Emma's contacts by accessing her phone, diary and computer over the years and not just in the months leading up to her death (paragraph 3.4) and this would cause arguments. This suggests a tendency to morbid jealousy on his part.

5.4. Information from the chronology suggests that one of the children had a period of time where their behaviour at school was noted as giving rise to concerns (paragraph 3.14). Insufficient school records do not enable further scrutiny of this information or to learn

whether the problems resolved over time. It is only through Health records that the Review Panel learnt that Emma took her child for a hearing assessment in case this was the basis for the difficulties being exhibited in school, although it would appear that the school were not informed of this. Research into the impact on children of living in households where domestic abuse takes place indicates a range of effects. Of significance are emotional and behavioural problems such as conduct disorders, and poorer outcomes at different developmental stages[8]. Even if physical violence is absent psychological and verbal abuse of a parent may still have a damaging effect including undermining self esteem, disruptive behaviour and difficulty in concentrating in school[9]. Whilst some children will have the resilience or other protective factors not to be effected by living in a family where domestic abuse takes place, it is important that the home environment is explored when assessing the aetiology of behavioural problems.

2. *To examine whether there were signs or behaviours exhibited by the perpetrator in his contact with services which could have indicated he was a risk to the victim or others*.

5.5. The report from Mental Health Services describes Gary as having a history of depression, anxiety, substance misuse and social difficulties. Through his adult years there appears a pattern of lack of motivation to address social issues including; unemployment and debt. His habitual use of cannabis and alcohol may have contributed to the ambivalence demonstrated to address his situation. Gary described a relationship with his partner which was prone to break up and reconciliation; however at the time of the murder he and his partner had been together approximately 25 years and had three children.

5.6. At the time of Gary's assessments by Mental Health Services in 2001, 2002 and in 2010 all practitioners described him as having pre-morbid personality traits which aligned him to; low mood, lack of motivation and poor coping strategies. This was demonstrated through his use of substances and his limited response to anti-depressant medications. There is no trace of any record to indicate that Gary did access the local drug services or counselling services as suggested by mental health practitioners; both services may have been able to offer him alternative methods of coping with life stressors.

5.7. The suicide attempt in 2002 was described as manipulative by Psychiatrist 2 in as much as this followed Emma's attempting to end the relationship; he had woken her to tell her of his attempt. He also asked the Psychiatrist to contact the Department of Work and Pensions on his behalf to advise then that he was unfit to work and request they reinstate his benefits. Despite Gary's displeasure that Emma had become pregnant during their relationship at all assessments he cited his children as a protective factor against acting out on suicidal ideations. Gary was always seen alone; Emma was not interviewed nor appeared to accompany him to his appointments, however, this may be because he was receiving treatment at a time when they were separated.

5.8. Gary never referred to domestic abuse within his relationship or described any controlling behaviours; there is no evidence to support or deny that any practitioner asked him about domestic abuse. Both referrals prior to 2014 would appear to stem from adverse life events; relationship breakdown (2001) and bereavement (2010).

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[88] Laing L, Humphreys C. (2013) *Social Work & Domestic Violence: developing critical & reflective practice*. London, Sage

[9] McGee C (2000) *Childhood Experiences of Domestic Violence*, London, Jessica Kingsley Publishers

Gary was deemed as low risk and therefore was managed in primary care services by his GP with whom Gary was reported to have a good relationship.

3. Agencies reporting involvement with the victim and the alleged perpetrator to assess whether the services provided offered appropriate interventions and resources, including communication materials. Assessment should include analysis of any organisational and/or frontline practice level factors impacted upon service delivery, and the effectiveness of single and inter-agency communication and information sharing both verbal and written.

5.9. Gary did not meet the criteria for Care Programme Approach (CPA) which would have provided him with a care coordinator; and his treatment was managed by his GP. This was an appropriate assessment of Gary's needs at both referral points.

5.10. There was good communication between the Consultant Psychiatrists and the GP; letters detailing the assessment and subsequent appointments carried out by the Psychiatrists were sent to the GP in a timely fashion and requests for information followed up appropriately. All assessments and appointments were offered responsively to Gary's needs. There appear to be no organisational factors which impinge on service delivery at the times of his assessments.

5.11. From the GP chronologies both Emma and Gary were offered appropriate and timely appointments. Gary had a greater number of appointments with his GP than Emma, and he appeared to have a good relationship with his GP and others in the surgery. There is confirmation in the chronology that his practice was kept informed by the Mental Health Team of the outcome of his assessments.

5.12. Emma and Gary had separate GPs in different locations in the district within which they lived. There were no occasions when it would have been necessary or appropriate for the practices to share information with each other or to seek permission from their patients to do so.

4. To assess whether agencies have domestic abuse policies and procedures in place, whether these were known and understood by staff, are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

5.13. The Norfolk and Suffolk NHS Foundation Trust (mental health services) has current domestic abuse policies in place for staff working with service users and carers. There is also a policy relating to staff as victims or perpetrators of abuse. These policies did not come into place until 2013. However, it is unlikely that having a policy in place in 2001 to 2010 would have led to a different approach to Gary's care and interaction with the organisation. There was no evidence or reports of domestic abuse shared with the Mental Health Trust, nor did Gary disclose any information which would imply he was a risk to others prior to 2014.

5.14. Emma's GP practice confirm that they have in place a domestic abuse policy. GPs have up to date information leaflets for their patients and contact details for MARAC in their consulting rooms. The practice waiting room also contains posters about domestic abuse.

5.15. Gary's GP practice has safeguarding children and safeguarding adults policies, but no specific domestic abuse policy. The Panel understands that the Clinical Commissioning Group advises GP practices to use the Royal College of General Practitioners policy toolkit, but this has not yet been adopted by the practice. It would be advantageous for staff in the practice if there was a policy on domestic abuse with

a clear referral pathway to guide staff when supporting patients affected by domestic abuse, either as a victim or perpetrator. The domestic abuse training undertaken by the practice is that covered by level 3 Safeguarding Children and Young People training; no dedicated domestic abuse training has been undertaken to augment this. GPs are taught about Multi-Agency Risk Assessment Conference (MARAC)[10] and have information packs and sources of support for both victims and perpetrators supplied by the Clinical Commissioning Groups within the county in addition to on-line resources. The practice does not have domestic abuse posters or other related sources of information on its waiting room notice boards for patients.

5. To examine the level of domestic abuse training undertaken by staff who had contact with the victim and/or the alleged perpetrator, and their knowledge of indicators of domestic abuse, both for a victim and for a potential perpetrator of abuse; the application and use of the DASH[11] risk assessment tool; safety planning; referral pathway to Multi Agency Risk Assessment Conference (MARAC), and to appropriate specialist domestic abuse services.

5.16. Since 2012 all mental health staff in the Norfolk and Suffolk NHS Foundation Trust (NSFT) receives basic awareness training in domestic abuse including DASH and MARAC at induction. All practitioners receive higher level safeguarding training within 6 months on commencing employment in NSFT which includes domestic abuse. Specific domestic abuse, Honour Based Violence and Female Genital Mutilation training is offered at advanced level to all staff. There is no record of training provision and content in 2001 available; in 2010 domestic abuse awareness was discussed within the generic safeguarding training. It is unlikely that had bespoke training been in place in 2001 or 2010 it would have led to a different approach to Gary's care by the organisation.

5.17. Emma's GP practice confirm that all GPs and nurses have undertaken level 3 safeguarding training and the non-clinical staff have all completed e-learning on safeguarding. Clinicians have all completed their renewable training within the last 3 years.

6. To determine if there were any barriers which may have affected the victim's ability to disclose abuse or to seeking advice and support.

5.18. As far as can be ascertain from the lack of contact with agencies apart from routine GP appointments there are likely to be no organisational barriers to affect Emma's access to services in the area or the county as a whole. Her GP practice has domestic abuse related posters in its waiting areas and the GPs have leaflets in their consulting rooms. (*Range of local options needed to inform reader of accessible agencies for both self referral and through agencies)*

5.19. The predominant barrier to Emma seeking advice and support lies in the fact that she did not see herself as a victim of domestic abuse. Her friends and family report that she was not afraid of Gary and she was unaware of any risk he might pose, particularly concerning an increase in risk to her brought about by what seemed to be a permanent end to the relationship on this occasion. Emma was to have had her 40th birthday in 2014 and her New Year messages to herself in her diary indicate that she

[10] MARAC is a multi-agency meeting to which high risk victims are referred where information is shared and a safety plan is devised and actions allocated to increase the safety of the victim.

[11] Domestic Abuse Stalking & Harassment (DASH): an evidence based list of 24 or 27 questions used to assess the level of risk a victim faces – standard, medium or high. High risk indicates referral to MARAC is needed. The threshold for MARAC referral is 14 or above positive answers to the DASH questions.

had made a decision that after 25 years of an on-off relationship with Gary she wanted a different life. She started to take steps to meet new people through dating websites with the possibility of a new relationship; a further increase in risk level.

5.20. One contributor commented that they loved each other, but were incompatible, and as many working in the field of domestic abuse will know many women will remain in a relationship because they love their partner and the belief that the relationship will change and improve in time. When there are children in the relationship the decision to separate can be doubly difficult to take, and indeed one friend thought Emma stayed in the relationship because of the children. Also Emma had known Gary from such a young age it was a familiar relationship to her, her only relationship, her normal; she had no experience against which she could compare what was acceptable and what was abusive or controlling.

5.21. The fact that physical violence appears to be absent from their relationship until the assault in May 2014, belies the subtlety of Gary's behaviour, his possessiveness during their relationship, and his unsuccessful attempts to control who Emma saw or communicated with (see 4.6). Many of the behaviours Gary exhibited are included in the DASH risk checklist because they add to the increase in risk to a victim. His suicide attempts or threats of suicide represent a risk factor which would be included in a DASH risk checklist. His harassment via text and phone calls becomes particularly significant when linked to his threats to harm himself and the couple's separation[12].

5.22. With the benefit of hindsight and using the facts revealed in this Review, had the May 2014 assault been reported a DASH risk checklist would have been undertaken with Emma and it is likely that 8 positive answers would have resulted. This would not have reached the criteria for a MARAC referral which is 14 positive answers, nevertheless, if professional judgement was to be used and the serious risks associated with separation and the other factors taken into consideration, it is possible in the author's judgement that a MARAC referral would have been appropriate. However, this is purely speculation; no report was made of this incident and no agencies were aware of what was taking place.

5.23. We may never fully know why their relationship endured for so long when there were so many differences; Emma hard working, organised with a routine to her life and many friends, as opposed to Gary who was long-term unemployed, habitually using heavy amounts of cannabis, unmotivated, unsociable and lacking in structure and routine to his life apart from regular nights at Emma's home and seeing his children at regular weekly intervals. But this is what he stood to lose due to Emma's decision to finally end the relationship, and according to his friends he had said that no one else was going to bring up his children. Friends now believe he held the attitude that if he could not have Emma then no one else would. He told one friend he would never have another woman after Emma. None of their friends or family thought he was capable of killing Emma and none recognised the risk.

5.24. From research we know that separation is the highest risk time for a former partner to commit fatal violence and the highest risk time is within the first 3 months after that separation and up to a year afterwards.[13]. Changes in circumstances heighten the risk for example Emma told Gary that she was not prepared to give him more time to change and the relationship was over changed his view of his situation; finding out that

[12] CAADA DASH risk assessment checklist and guidance

[13] Monkton Smith J, Williams A, Mullane F (2014) *Domestic Abuse, Homicide & Gender, Strategies for Policy and Practice* Plagrave Macmillan, Basingstoke.

she was using dating websites was a further change which escalated the risk, and finding a note in her diary which made him think she was about to meet someone new was probably the final escalator in risk which triggered the fatal attack by him. However, Emma and her family and friends were unaware of this pattern of behaviour associated with domestic abuse and the risk Emma faced.

7. In liaison with the Police Family Liaison Officer the chair/author to contact family, friends, and colleagues to invite their contributions to the Review and, whilst acknowledging the pitfalls of hindsight, seek their views as to whether anything needs to change to reduce the risk of similar events in future.

5.25. This final part of the terms of reference has been completed by the Review author. All family and friends interviewed were asked for their views on what changes if any could be made to reduce the risk of a similar tragic incident in future, but they all struggled to see how this could be done. They had all been very shocked by the events which had taken place.

Example of Good Practice

5.26. Although some time ago it is worth comment that the liaison between the Mental Health Services and Gary's GP practice represented good practice. The detail provided from the mental health assessments gave his GP helpful information which added to their knowledge and ability to treat him in the community.

Early Learning

5.27. The very limited agency involvement and time taken to undertake interviews meant there were no early learning opportunities from this Review.

6. Conclusions

6.1. The fact that criminal justice and domestic abuse agencies had no contact with Emma or Gary, and the fact that their contact with Health agencies was fairly limited and routine meant there was no opportunity to intervene or support Emma in 2014 when she separated from Gary. The children's schools also appear to have no indication that all was not well at home. With hindsight and the knowledge we now have from family and friends it is possible to see the escalation in risk that was taking place between January and June that year when the couple separated for what appeared to be for the final time. However, Reviews are urged to avoid hindsight, therefore with the knowledge, or rather lack of knowledge agencies had at the time the Panel concludes that Emma's death could not have been predicted.

6.2. If the assault by Gary on Emma in May 2014 had been reported to the Police there is a chance that his behaviour could have been challenged appropriately and he may not have taken the actions he did. It is unlikely that if charged with that assault he would have been given a custodial sentence as he had no previous criminal record therefore he would still have been at liberty. Gary's statements to his friends that he would kill Emma, the evidence of pre-planning, and his possessiveness of her mean that Emma's death could not have been prevented by anyone other than Gary himself.

Lessons Learnt

6.3. The main lesson arising from this Review centres on the need for greater public understanding about all aspects of domestic abuse and particularly around behaviours which indicate escalating risk. This is needed not just to help victims recognise behaviours which are considered abusive or controlling, but also for family, friends, colleagues, employers, and the community to recognise the risk factors associated with domestic abuse. Information needs to include what domestic abuse and coercive control is, what constitutes an increase in both risk for victims and from perpetrators. For example risk posed by separation and behaviours such as online stalking (via computer and phone, reading text messages etc), acts of coercive control, threats of suicide, and morbid jealousy.

6.4. This Review demonstrates the genuine obstacles faced by friends or family of a victim or of a perpetrator who have information disclosed to them which reveals domestic abuse behaviours have taken place, or may take place. Those who knew of the assault on Emma in May 2014 felt they had a duty to respect her wishes for confidentiality by not reporting the assault. None had the knowledge to appreciated the importance of the information in the context of the growing risk to Emma posed by Gary's behaviour. None of the perpetrator's former friends believed his pronouncements that he was going to kill his ex-partner; they thought it was part of his general complaining about Emma. Coupled with a greater public understanding of domestic abuse and its associated risks, ways need to be found for those with information to share the burden of this knowledge safely, and if necessary anonymously, to try and reduce such incidents happening in future.

6.5. Neither Emma nor Gary presented to any organisation in a way that appeared to indicate they may be a victim or a perpetrator of domestic abuse. It is nevertheless worth acknowledging that professionals can understandably struggle with identifying and assessing potential perpetrators, and with identifying victims of domestic abuse who do not even recognise themselves as victims. Whilst no agency appears to have missed any signs or symptoms of domestic abuse, this Review emphasises the importance for all organisations to ensure that they have domestic abuse policies with clear referral pathways. These should be supported by training which is in enough depth to cover all the complexities of domestic abuse, coercive control, barriers to seeking help, and the risk inherent in separation that this case highlights. As GPs are a universal service and are high on the list of agencies women affected by domestic abuse will approach[14], it is important that GP practices are among the agencies to adopt a domestic abuse policy, a referral pathway to guide staff [15], and domestic abuse training which helps them recognise the signs and symptoms which can indicate when a patient may be a victim or perpetrator of such abusive and controlling behaviour. In addition the display of information and poster on domestic abuse in waiting rooms not only gives information direct to patients, but gives the message that this is a practice where a patient can feel comfortable and confident in disclosing and discussing domestic abuse. The Panel is aware that one GP practice in this case did have a domestic abuse policy and materials in their waiting room, but that one did not.

6.6. Although insufficient information from school records or other sources was available to firmly evidence and confirm the possible adverse effects on the children in the family, the impact of living with domestic abuse on children should not be underestimated. As

[14] Domestic violence: a health care issue? British Medical Association 1998

[15] A domestic abuse care pathway as recommended by the Royal College of General Practitioners, IRIS, and CAADA: this can be found at http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx

highlighted in paragraph 5.4 the abuse does not have to be physical violence; witnessing or hearing psychological and verbal abuse of a parent may still have a damaging effect. It is therefore essential that professionals working with children are aware of the behavioural and psychological signs that can indicate a child is being affected by domestic abuse in the home, and children's inherent wish to be loyal to their parents which can hamper their ability to be open about their concerns and experiences. A safe place and a trusting relationship is needed to support children to talk about their situation. This may be a school counsellor or an appropriate helpline which could be publicised in schools.

Recommendations

6.7. The following recommendations arise from Panel discussions concerning the information gathered, the report provided, and the lessons learnt from this Overview Report.

Recommendation 1:

A communications strategy should be developed aimed at increasing the knowledge and understanding of domestic abuse, coercive control and associated risk among potential victims, family, friends, colleagues, employers, and the community. The campaign should include appropriate sources of support for children, and profile abusive behaviours used by perpetrators with the aim of challenging the behaviour and making it socially unacceptable.

Recommendation 2:

A safe and if necessary anonymous reporting mechanism should be identified for third party reporting of concerns by those who have knowledge of domestic abuse being experienced or perpetrated by someone they know.

Recommendation 3:

Domestic abuse training should incorporate learning from this and any future DHRs and must include examples of high risk behaviours by perpetrators, the impact on victims, the complexities of working with victims who lack knowledge or who are in denial about domestic abuse, and stresses high risk circumstances including separation.

Recommendation 4:

Organisations must ensure that the appropriate level of domestic abuse training is undertaken by staff for them to perform their role effectively to identify indicators of domestic abuse and know how to respond.

Organisations to be included in this recommendation are listed below. This list is not exhaustive and others should be included as required:

- Suffolk County Council Children & Young People's and Adult's Services
- Schools
- Health – GPs, and all sectors
- Suffolk Constabulary
- All Safeguarding Adults and Safeguarding Children partner agencies.

Recommendation 5:

The content of training programmes for schools should include the importance of, and need to, ensure that matters giving rise to concern about a child's behaviour or performance are fully recorded, including actions taken and outcomes.

Recommendation 6:

To ensure that domestic abuse training for schools includes the impact on children of living with domestic abuse and how to sensitively establish if such factors may be impacting on a child where there are concerns about school attainment or behaviour.

Recommendation 7:

All GP practices to have in place a domestic abuse policy and a referral pathway as recommended by the Royal College of General Practitioners and the Clinical Commissioning Group, and that all practice staff are supported with domestic abuse training to enable them to put the policy and pathway into practice.

SUFFOLK COASTAL DOMESTIC HOMICIDE REVIEW - ACTION PLAN

APPENDIX A

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Progress Indicator	Date of completion and Outcome
What is the over-arching recommendation?	*Local, regional or national level?*	*How relevant agency will make this recommendation happen? What actions need to occur?*				Red Amber Green	
Recommendation 1: A communications strategy should be developed aimed at increasing the knowledge and understanding of domestic abuse, coercive control and associated risks among potential victims, family, friends, employers, and the community.	County Level & Local level	Develop & deliver a county wide public & professional communication campaign promoting understanding of domestic abuse. Ensure this is included in the County DA Strategy 2015 -2018. Identify funding for campaigns. In consultation with appropriate members of the public develop DA posters and leaflets aimed at family and friends to complement existing materials. In liaison with the Health & Wellbeing Board agree funding & process for disseminating to local GP practices & health outlets briefings & awareness raising materials & sources of support. Include a social media presence at the forefront of an open ended campaign, to offer advice & information to target groups, individuals and communities. Use Facebook Ads where appropriate, include information containing pictures, links to film clips and videos.	Suffolk County Council Community Safety Partnership Supported by Suffolk Coastal CSP	Action plan drafted for consultation Campaign plan, delivery partners and start date agreed. Including exploring/establishing funding support for materials Sources of funding support agreed. Focus group established and materials developed & agreed Develop information pack for GP's/Health Campaign launch Include hashtag (#) both to promote and to collate re-tweeted and shared messages to enable feedback and evaluation Quarterly progress to be reported to Suffolk Coastal CSP Board until completed.	September 2015 October 2015 November 2015 November 2015 December 2015 / New Year 2016 Ongoing	RED RED RED GREEN	Outcome: A regular programme of public information from which family, friends, employers and the wider community gain a greater understanding of domestic abuse, coercive control and risk, and better able to act to support those experiencing domestic a Date completed:

SUFFOLK COASTAL DOMESTIC HOMICIDE REVIEW - ACTION PLAN

RECOMMENDATION	Scope of recommendation	Action to be Taken	Lead Agency	Key milestones to enact recommendation	Target Date	Progress Indicator	Date of completion & Outcome
Recommendation 2: A safe and if necessary anonymous reporting mechanism should be identified for third party reporting of concerns by those who have knowledge of domestic abuse being suffered or perpetrated by someone they know.	County Level	Develop with Suffolk Constabulary and Crimestoppers or other appropriate agency, anonymous third party reporting of domestic abuse. Target 'message' to friends, family, neighbours & work colleagues to anonymously contact Crimestoppers if they suspect domestic abuse occurring. Develop promotional materials & information for Safer Neighbourhood Teams to distribute to town and parish councils to encourage awareness of additional service offered by Crimestoppers in communities	Police & Crime Commissioner Supported by Suffolk Constabulary And Crimestoppers	Suffolk Constabulary meet with partners and provider to consider Suffolk Scheme and timescales Key message agreed and publicity arranged. Implementation date set and agreed. Safer Neighbourhood Team information developed and briefings with teams arranged Scheme implemented and publicised. Quarterly progress to be reported to Suffolk Coastal CSP Board until completed.	By November 2015 December 2015 January 2016 March 2016	GREEN	Outcome: Third parties have a secure and confidential mechanism to share concerns and information to reduce risk to victims and prevent a perpetrator committing a crime. Date completed:

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RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Progress Indicator	Date & Outcome
Recommendation 3: Domestic abuse training should incorporate learning from this and any future DHRs and must include examples of high risk behaviours by perpetrators the impact on victims, the complexities of working with victims who lack knowledge or who are in denial about domestic abuse, and stresses high risk circumstances including separation. Minimum training content listed in **Appendix A of action plan.** This is available free and open to all agencies.	.County Level	Apply for funding for additional training courses. Hold a learning event to disseminate findings and learning to Managers, strategic leads and relevant councillors. Review all levels of domestic abuse training content including components within Safeguarding training, to incorporate learning from DHR and ensure content of this recommendation (& Appendix A) is included. Include additional delivery dates in annual training programme for Foundation in DA & HBV course and MARAC, Risk assessment & safety planning course. NSNHS Trust provides basic awareness domestic abuse training at induction for all its staff & ensure inclusion of domestic abuse in both Safeguarding Children and Adult mandatory training both of a day duration. Trust to provide exclusively to its staff domestic abuse day's module focusing on domestic abuse and another focusing on the Toxic Trio-Mental Health, Domestic Abuse & Substance Misuse. Attendance at bespoke sessions recorded on Trust training system LARA. Trust is 92% compliant for attendance at induction sessions above minimum requirement of 90%. Safeguarding Adults Training – Trust currently 93% compliant and Safeguarding Children Training– 92% compliant. Both above minimum requirement of 90%. Trust has information on the internal Safeguarding intranet page, &	Suffolk County Council Domestic Abuse Community Safety section Supported by Workforce Development Norfolk & Suffolk NHS Foundation Trust (NSNHST	Budget for additional courses and admin support agreed with Workforce Development. Training dates agreed co-facilitators & venues booked for DHR dissemination events. Training dates published in brochure and online Training course content review completed and revisions made as necessary. Norfolk & Suffolk NHS Trust Actions Completed Breakdown audit of staff attendance on training courses by agency and summary of evaluations completed on line by participants provided to CSP. Findings to agencies for following year planning of staff training. Quarterly progress to be reported to Suffolk Coastal CSP Board until completed.	Nov 2015 October/ Nov 2015 October / Nov 2015 18th May 2015 End of March each year from 2016	GREEN	Outcome: Those attending training are knowledgeable and skilled in recognising all aspects of domestic abuse, coercive control and risk, and able to take appropriate action to support victims and challenge perpetrators. Date Completed:

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RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Progress Indicator	Date of completion and Outcome
Recommendation 4: Organisations must ensure that the appropriate level of domestic abuse training is undertaken by staff for them to perform their role effectively to identify indicators of domestic abuse and know how to respond. Organisations to be included in this recommendation are listed below. This is list is not exhaustive and others should be included as required: • Suffolk County Council Children & Young People's and Adult's Services including Education. • Schools • Health – GPs, and all sectors • Suffolk Constabulary • All Safeguarding Adults and Safeguarding Children partner agencies.	County Level	Organisation's training departments and supervisory managers to audit staff's level of domestic abuse training to ensure it is sufficiently in depth to meet the needs of their staff. Staff with a frontline assessment role identified to receive dedicated domestic abuse training which is available free (see Appendix A). Training needs identified through audit gathered together to form annual training plan. Domestic abuse training included in staff annual appraisal development plan.	Safeguarding Adults/ Safeguarding Children Board Supported by Workforce Development & Suffolk County Council Domestic Abuse Community Safety Section Norfolk & Suffolk NHS Foundation Trust (NSNHST)	Organisation's staff training audit complete, need identified and factored into training plan. Organisations and their supervisory staff informed of training and recommendation to include in staff annual appraisal development plans. Staff trained by agency fed back from year end breakdown of attendances to training departments for monitoring and planning staff training needs for coming year. Quarterly progress to be reported to Suffolk Coastal CSP Board until completed.	January 2016 January 2015 February 2016 End of March each year from 2016		Outcome: All organisations have mechanisms in place to ensure that staff are trained and knowledgeable about all aspects of domestic abuse and coercive control and risk assessment. Date completed:

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RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Progress Indicator	Date of completion and Outcome
Recommendation 5: The content of training programmes for schools should include the importance of, and need to, ensure that matters giving rise to concern about a child's behaviour or performance are fully recorded, including actions taken and outcome. **Recommendation 6:** To ensure that domestic abuse training for schools includes the impact on children of living with domestic abuse and how to sensitively establish if such factors may be impacting on a child where there are concerns about school attainment or behaviour.	County Level	DHR Chair to write to Local Safeguarding Children Board (LSCB) to inform them of recommendation to enable Board discussion and discuss action which can be taken. County Council domestic abuse coordinator to liaise with School Choices, providers of training to schools, to establish whether issue included in current training. Absence of recording in training to be addressed. or Presence of recording in training to be confirmed. Establish level of domestic abuse training included in current training programme. Update content of training if required to meet needs of recommendation via Liaison with county domestic abuse coordinator re: content. Revised training programme agreed and ready for delivery to schools.	Local Safeguarding Children Board Suffolk County Council Domestic Abuse Community Safety Section	Letter send to LSCB *Chair* and confirmation of receipt received. Follow up discussion re: appropriate agency to take action. Appraisal of recording standards content of schools training achieved Any necessary inclusion or strengthening of training programmes on effective recording completed. Contact made with School Choices and review of domestic abuse training for schools undertaken Content revised as required and training programme available for delivery	15 June 2015 23 June 2015 September 2015 January 2016 October 2015 January 2016	GREEN	Outcome: Concerns for children clearly recorded with outcomes to ensure school staff are aware and children receive the support they need. Date completed: Outcome: Opportunities to identify children for whom living with domestic abuse is having a detrimental impact on their development and achievement increased to enable appropriate and safe support to be given.

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RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Progress Indicator	Date of completion and Outcome
Recommendation 7: All GP practices to have in place a domestic abuse policy and a referral pathway as recommended by the Royal College of General Practitioners and the CCG, and that all practice staff are supported with domestic abuse training to enable them to put the policy and pathway into practice.	County Level	CCG Designate Team produce brief guidance based on the RCGP Toolkit accompanied by GP Safeguarding Resource Kit to encourage the development of a practice policy/ protocol. Practices still to implement a domestic abuse protocol and referral pathway supported to do so if required. Appropriate training for clinical and non clinical support staff explored, funding identified and training commissioned. Posters and materials for practices sourced - see recommendation 1 re: county communications strategy to access resources	East Suffolk CCG	Brief guidance & supporting documents sent out to GP practices. GP practices contacted and offered assistance to implement if required. Posters and other resources supplied to practices Numbers of practice staff identified in need of training to inform training plan and means of delivery best suited to practices agreed. Dedicated GP practice training funding secured Training commissioned and commences delivery Aim for all county's GPs to have domestic abuse policy and pathway by Training delivered to all practices by Quarterly progress to be reported to CSP Board until completed.	October 2015 November 2015 November 2015 April 2016 September 2016	GREEN	Outcome: GPs and practice staff better able to identify and support those who are victims or perpetrators of domestic abuse and refer on appropriately. Date completed:

APPENDIX B

ESSENTIAL COMPONENTS FOR INCLUSION IN DOMESTIC ABUSE TRAINING

- Definition and types and examples of domestic abuse and coercive control.
- Effects on victims.
- Barriers to seeking help, including barriers for victims in recognising their situation is abusive.
- High risk situations including heightened risk at times of separation and in relation to child contact.
- The importance of dynamic risk assessment and reassessment according to changing circumstances.
- High risk perpetrator profiles and behaviours.
- Effects on children to age and development, what to look, for and sources of support available for children and young people in schools, locally in county, online etc.
- Safety planning with victims according to their assessment of their needs and risks.
- Sources of local and national specialist support.
- Methods for all agencies to refer to MARAC.
- The importance of recording and safely sharing and coordinating information and actions.
- Sensitive and appropriate ways of asking about domestic abuse.

These components are confirmed as already covered in the 4 multi-agency training modules endorsed by the Suffolk Local Safeguarding Children Board (LSCB) and Suffolk Constabulary and offered free to all statutory and voluntary agencies in Suffolk. There are usually at least 20 multi-agency training days each year plus additional single agency in house when required. Full day modules are: Foundation in Domestic & Honour Based Abuse; MARAC, Risk Assessment and Safety Planning; Children & Domestic Abuse; Working with young people affected by teenage relationship abuse. Course content is updated regularly and the learning points from the DHR will be incorporated as a matter of course. This is in addition to the Safeguarding Training offered by LSCB

APPENDIX C

Home Office

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Councillor Steve Gallant
Community Safety Partnership Chair
Cabinet Member for Community Health
Ward Member for Felixstowe East
Suffolk Coastal District Council

23 September 2015

Dear Councillor Gallant

Thank you for submitting the Domestic Homicide Review report for East Suffolk to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25 August 2015.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be a well-structured, engaging report that was probing and thorough. The report provided a clear picture of the circumstances leading up to the death despite the lack of agency contact. The Panel suggested that this report should be used as a model of best practice once published.

The Panel noted the following errors which you may wish to consider before you publish the report:

- Please check paragraphs 2.1 and 3.1 as conflicting locations are given for Emma's birthplace (Suffolk and the Midlands);
- There is an error in paragraph 6.2;
- Please proof read the section "Lessons Learnt" as there are a number of errors;

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR QA Panel