

CHELTENHAM STRATEGIC LEADERSHIP GROUP



Domestic Homicide Review

Under s9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of a woman

Overview report produced by independent Chair
Dr Jane Monckton-Smith

Final – for publication
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Glossary

GDASS: Gloucestershire Domestic Abuse Support Service

CBH: Cheltenham Borough Homes

CBC: Cheltenham Borough Council

DHR: Domestic Homicide Review

SIO: Senior Investigating Officer

FLO: Family Liaison Officer

TOR: Terms of Reference

IMR: Individual Management Review

GDVSAP: Gloucestershire Domestic Violence Support and Advocacy Service

MASH: Multi-Agency Safeguarding Hub

Cheltenham Strategic Leadership Group is the relevant Community Safety Partnership for the purposes of this Domestic Homicide Review and has coordinated the review in-line with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published in August 2013

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Preface

I would like to begin this report by expressing my sincere sympathies, and that of the panel, with the family and friends of *Susan* who is remembered as a loving and caring mother and grandmother. Susan is remembered universally as a kind, gentle and fun loving person who is keenly missed. I am sorry for their loss and hope that in some way this report gives voice to Susan's story. During the course of this review we have kept Susan's photo visible at panel meetings, and we never forgot that she was a real and loved person. This report has considered the perspective and testimony of family equally alongside professional records to better understand what happened and to maximise learning, this is in line with Home Office guidance for the conduct of DHRs.

The purpose of a Domestic Homicide Review (DHR) is to identify improvements which could be made to community and organisational responses to victims of domestic abuse, and hopefully to try and prevent a tragedy like this from ever happening again.

I would like to thank the panel, and those who provided chronologies and Individual Management Reviews (IMRs), for their time, patience and cooperation. I would also like to thank members of Susan's family for their contribution, and the time they gave to this review. The family have suffered terribly for many years and further suffering must be avoided wherever possible. For this reason the report author has excluded some information which may identify individuals, like specific dates, and detail of certain incidents, and some information the family would like to remain private. *Susan* and *Peter* are pseudonyms agreed with the family. It is considered by the Chair that Peter may still pose a risk to certain members of the family and further suffering must be avoided.

It is important to remember that this homicide occurred in late 2013, and since this time there have been changes to some agency practices and procedures. Notably, there have been significant developments in the Police and Housing approaches to Domestic Abuse, and this should be considered when reading the chronology of events.

1.0 Executive Summary

- 1.1 It should be recognised in this case that significant abuse occurred over a forty year period, and consequently the summary is longer than might be expected.
- 1.2 The victim *Susan* was a 57 year old woman who lived alone in supported housing in Cheltenham, Gloucestershire. She was killed in (date excluded for anonymity) 2013 in her own home when her former husband *Peter* (also 57) strangled her. Her body was discovered in 2013 having apparently been deliberately hidden beneath bedding.
- 1.3 Susan suffered with serious ill health which affected her life and physical choices. Such was the severity of her medical condition, that by 2013 when she died, she was considered to be terminally ill. Susan would have found it difficult to walk long distances or exert herself. For this reason she was living in housing ordinarily reserved for those over the age of 65. Susan had declined to have daily visits from the wardens and was living an independent life.
- 1.4 Susan had been married to Peter and they had two children together, a son and a daughter, but at the time of her murder they had been divorced for over ten years. The separation had occurred because of Peter's violence and abuse towards Susan, and a reported incident of violence to one of the children (when they were 14 years old) for which he was arrested and charged. Susan said in interview that she left Peter because Social Services had threatened to take away her children if she did not, and she also said that the children were often taking her place as a focus for Peter's violence.
- 1.5 Peter continued to use violence against Susan and exert control over her even after she left him. There is no doubt that she was very frightened of him and told people she thought he would kill her. Her family say 'she was frightened to death of him' and 'she never felt safe anywhere'. It is apparent that Peter continued to have a significant presence in her life and despite some considerable effort on her part to keep him away; she had little choice but to tolerate his presence in her life and home.
- 1.6 Susan maintained a close relationship with her children and her wider family. She appeared to live a quiet life, which was dominated by Peter and his abuse. She told of violence and threats against her family and her children, which made her very frightened to make complaints against him. Family members have also told this review of significant control, stalking and abuse by Peter. In interviews and a recorded telephone call to police Susan told of becoming more and more isolated as Peter threatened her friends and made it impossible for her to have a social life. In various records, and conversations with family, she told of beatings, rape and death threats.
- 1.7 Susan also had significant housing problems which caused her to move many times to try and escape Peter. She spent some time in refuges, notably one in Swindon. In 2005 Susan reported an incident had occurred in which Peter put his hands around her throat and strangled her until she lost consciousness. Susan reported a further incident of strangulation assault from Peter to the police two months later. Given her very serious medical condition which could make breathing difficult in ordinary circumstances, her fear that she would be killed is brought into sharp relief.
- 1.8 After Susan reported the second strangulation assault, Peter absconded from the UK apparently, at some level, to escape justice, spending some considerable time in Thailand. However, he returned to the UK and the violence and control began again. He had regular access to Susan's home for contact with his children and grandchildren; he also evidently had some control over her finances and those of the children.

- 1.9 The sale of the marital home was the cause of some considerable stress. Susan was too frightened to live there, and Peter made it impossible for her to sell it. Family say that 'he wouldn't even let her have a tea-spoon' from the house when she left. When it was finally sold after many years he attempted to get her share of the money by threat and violence.
- 1.10 At some time Peter was in a relationship with another woman, the detail of which is not in the scope of this report. But it has been disclosed to the police by this woman that Peter was similarly controlling of her and she was very frightened of him.
- 1.11 Susan and Peter appeared to have a lot of contact in the last months of her life. Peter reported Susan for benefit fraud and she was investigated for that offence in the months before her death.
- 1.12 The basis of the accusation was that Susan had benefitted from the sale of the marital home when she separated from Peter, but had not declared the money in her formal claims for housing and other benefits.
- 1.13 Peter made some attempts to withdraw his allegations just before Susan's death when he realised that he was also going to be subject of the investigation as he had also benefitted from the sale of the marital home, and had also not declared the money. It is apparent that the situation was getting out of Peter's control and he had started to panic.
- 1.14 As a result of these allegations Susan's housing benefits were suspended, and she reported to others that she was having difficulty paying her rent. Cheltenham Borough Homes had started processes to seek to take possession of Susan's home.
- 1.15 Family members state that Susan was terrified of the investigation and sincerely believed she would go to prison.
- 1.16 In late 2013 Susan suddenly failed to turn up for some family engagements with no explanation. This was very unlike her, and her family became concerned when they could not make contact. They managed to gain entry to her home with the help of the warden at the supported housing but did not find Susan there.
- 1.17 When approached, Peter told the family that he was in contact with Susan by phone, and that she was staying in the West Country. The family were suspicious of this story, and some twenty two days after she went missing, police gained entry to her home and discovered her body lying in her bed deliberately hidden by bedding and a pillow. She had been strangled.
- 1.18 Peter was arrested and charged with murder. He was convicted of murder at Bristol Crown Court and sentenced to life imprisonment with a 16 year tariff. Peter denied any involvement in Susan's death throughout the trial.
- 1.19 During the course of the relationship, a period of some forty years, Susan had contact with a number of agencies and organisations where she disclosed the abuse, and in some examples, requested help. She had contact with the police, housing agencies, health services and the housing benefit fraud department.

2.0 Purpose of the Review, Process, Scope and Terms of Reference

- 2.1 The purpose of the review is not to reinvestigate the death or apportion blame, but 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, and to identify clearly what those lessons are, both within and between agencies.
- 2.2 It will establish how those lessons will be acted on, within what timescales, and what is expected to change as a result, and then apply those lessons to service responses including changes to policies and procedures as appropriate; and to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children, through improved intra and inter-agency working.
- 2.3 The Terms of Reference were articulated thus:

2.4 Purpose of the panel:

To establish the facts about events leading up to the murder of Susan

To examine the roles of the organisations involved in her case, the extent to which she had involvement with those agencies, and the appropriateness of single agency and partnership responses to her case.

To establish whether there are lessons to be learned from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard her wellbeing.

To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.

To identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in Gloucestershire in order to improve their work to better safeguard victims of domestic abuse.

2.5 The scope of the panel review

To produce a chronology of events and actions leading up to the death of the victim, Susan, from the period 1st January 1999 until she was discovered deceased in 2013; seeking information from:

- Organisations which had contact with her
- Local community organisations
- Her family and friends

To review current roles, responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what should have happened

To review this against what actually happened to draw out the strengths and weaknesses

To review national best practice in respect of protecting adults from domestic abuse

To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse

The review will also specifically consider:

An assessment of whether family and friends were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons).

A review of any barriers experienced by the family in reporting any abuse or concerns, including whether they, or the victim, knew how to report domestic abuse had they wanted to.

A review of any previous concerning conduct or a history of abusive behaviour from the perpetrator and whether this was known to any agencies.

An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in Gloucestershire.

Whether the perpetrator had any previous history of abusive behaviour towards this victim, or any previous partner, and whether this was known to any agencies.

Whether family and friends wanted to participate in the review. If so, find out if they were aware of any abusive behaviour by the perpetrator prior to the homicide.

Communication to the general public and non-specialist services about available specialist services related to domestic abuse or violence.

Whether the work undertaken by the service in this case is consistent with its own: professional standards, compliant with its own protocols, guidelines, policies and procedures

Any other information that becomes relevant during the conduct of the review

- 2.6 The panel was made up of representatives of those organisations that had some involvement in the victim's life, those that have duties to care for adults at risk of domestic abuse, and those that have local knowledge and insight.
- 2.7 In the initial scoping a number of agencies were identified as having had contact with Susan and Peter and they provided the review panel with a written chronology detailing the nature of that contact. Those agencies with significant contact were asked to provide the panel with an Individual Management Review (IMR). Significant contact was not measured solely by the amount of that contact, but also the importance and relevance of it. The authors of the reviews had no direct contact with the case. Chronologies were provided by:

Gloucestershire Hospitals NHS Foundation Trust (Acute Healthcare Trust)

Gloucestershire Constabulary

Gloucestershire County Council - Adult Services

Gloucestershire County Council Children's Services

Gloucestershire Domestic Violence Support and Advocacy Project (GDVSAP)

Cheltenham Borough Homes

Cheltenham Borough Council (benefit and fraud investigation)

Gloucestershire Care Services

Tewkesbury Borough Council Housing Team

IMRs were provided by:

- Gloucestershire Constabulary
- Cheltenham Borough Homes
- Gloucestershire Hospitals NHS Foundation Trust (Acute Healthcare Trust)
- Cheltenham Borough Council benefit and fraud investigation department
- Gloucestershire Care Services

2.8 The authors of the IMRs were in every case independent of any involvement in the case.

2.9 The IMR authors presented their reports and their recommendations in person to the panel, and were available then to answer questions about their agency's involvement and any recommendations they made. The panel met on at least ten occasions to discuss the antecedent history and to consider the IMRs. There was a substantial time period to consider in this case as the abuse, control and violence had spanned some forty years. The period for scrutiny of agency involvement is restricted to the dates when that involvement is first documented, which is from 1999. However, family knowledge stretches further back and sets some context so was not constrained by the dates set in these terms of reference for agencies.

3.0 Timescales

- 3.1 The Gloucestershire Safeguarding Adults Board (GSAB) was first informed of the death on the 13th September 2013
- 3.2 The Independent Chair of the GSAB reviewed the circumstances of the death against the criteria set out in the *Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*, consulting with the domestic abuse strategic lead for Gloucestershire. On 13th September 2013 it was recommended that a DHR should be undertaken and the Home Office was informed on the same day.
- 3.3 In line with Home Office guidance, the review was undertaken by Cheltenham Strategic Leadership Group.
- 3.4 Cheltenham Strategic Leadership Group was informed in October 2013 and they commissioned Dr Jane Monckton Smith to act as the Independent Chair and report author on 3rd December 2013. Dr Monckton Smith is a specialist in domestic homicide and works for the University of Gloucestershire. She does not work for any of the agencies which had contact with Susan or Peter, and she is independent of any agency that had involvement with the case.
- 3.5 The review was undertaken in accordance with Home Office guidance and was conducted in such a way so as not to compromise or prejudice current and ongoing criminal proceedings.
- 3.6 There was a criminal prosecution pending as Peter had been charged with Susan's murder. It was decided that the review could not formally begin until the trial was over, however it was decided the panel should meet to draft the Terms of Reference.
- 3.7 The panel and Chair formally met for the first time on the 6th December 2013 and the Terms of Reference (TOR) were drafted. The Chair was conscious that she wanted the family to have the opportunity to review the TOR but at this stage felt it important to produce a draft and seek their input at the end of the trial.
- 3.8 Susan's family were invited to be part of the review, and were written to by the Independent Chair before the trial, and then again after the trial, to invite their participation. It is not unusual for such tragic events to create divisions and hurt within a family, and there were such divisions evident in this case. These divisions were made known to the Chair by the Police Family Liaison Officer, the Homicide Service, and the Senior Investigating Officer. Susan's children decided not to participate in this review in the beginning, but other members of Susan's family did. One of Susan's children participated in the review at a later stage in the process.
- 3.9 The trial was concluded in late 2014 and Peter was convicted of murder.
- 3.10 The chair was unable to meet with the family until after the trial because some members of the family were significant witnesses. The first arranged meeting after the trial had to be cancelled and re-scheduled because of serious events affecting the family which could not have been predicted. The chair was able to meet with them when they were feeling able to contribute in February 2015. The scope of the review was discussed with them in detail, and their considerations and requests fully integrated into the Terms of Reference and the report.
- 3.11 The business of the panel began after the trial in late 2014. An inquest was opened and adjourned and will not be continued. There are no other parallel reviews or inquiries.

- 3.12 When the first draft of the Overview Report was completed the Independent Chair contacted Susan's children who had previously decided not to participate in the review, to give them the opportunity to see the report before it was submitted to the Home Office, and to contribute if they so wished. One of Susan's children decided after meeting with the Independent Chair that they would like to contribute, so submission of the report was again pended to allow this to happen.
- 3.13 The Independent Chair had three meetings with Susan's child and their perceptions and experiences were then included in the report.
- 3.14 This activity has meant that the report is later being submitted than the stipulated preferred timescale referred to in the guidelines.

4.0 Methodology

- 4.1 The method for conducting a DHR is prescribed by Home Office guidelines. This DHR followed those guidelines in the usual way. After the trial, there was no concurrent review, and the business of the panel did not formally begin until the trial had ended in 2014. It is important that the Independent Chair observe the rules of disclosure which can become difficult if a review begins before a trial is ended, especially where family are key witnesses. This observation extended the time within which this review was conducted, and the Home Office were informed of the delay in beginning.
- 4.2 All agencies in the area were contacted to search for any contact they may have had with Susan and her immediate family, and also Peter. If there was any contact then a chronology detailing the specific nature of the contact was requested. Those agencies with contact considered of importance to the panel were asked to provide an Individual Management Review. This allows the individual agency to reflect on their dealings with the family and/or the offender and identify areas which could be improved in the future, and make recommendations. Upon receipt of the chronologies and the IMRs a composite chronology was produced by the Independent Chair.
- 4.3 The IMR authors were not directly involved with the case. They all presented their reports to the DHR panel and were available then to answer questions about their involvement and the recommendations they may have made.
- 4.4 In addition to this, Susan's GP was interviewed by the Independent Chair. A summary of that interview was provided to the panel. A recording of a telephone call made to police by Susan was played to the Independent Chair and a summary of that conversation was provided to the panel. Three interviews under caution between Susan and Cheltenham Borough Council benefits fraud department were provided for the panel.
- 4.5 The Independent Chair also met with members of Susan's family at their home address. She met with the family on five occasions and with Susan's child on three occasions, and discussed Susan's life with Peter at length. The family members provided the review with their perceptions and experiences of Susan's life, and records which helped support their narratives. This is in line with Home Office guidance for the conduct of DHRs. The family were also provided with a draft of this report to read and comment on so further input could be facilitated. The Independent Chair went through all of the report with them to answer any queries or questions, and take suggestions.
- 4.6 The panel also had a verbal summary and history of the investigation from a representative of Gloucestershire Constabulary. The Independent Chair was provided with copies of statements from police officers, witnesses, and some statements made by Susan.
- 4.7 The Crown Prosecution Service was asked to contribute to the panel to speak more generally about the way decisions about charging are reached. The Independent Chair visited the Deputy Chief Crown Prosecutor in their Bristol offices to talk about how charging decisions are reached, and the kind of training CPS direct, and CPS lawyers receive. This was extremely useful information for the panel.
- 4.8 All panel members were asked to present their own perspectives on recommendations which they thought should be made in the final report. Each of these suggestions was discussed by the panel.
- 4.9 The panel considered the actions of Gloucestershire Constabulary, Cheltenham Borough Council (housing), Tewkesbury Borough Council (housing), Gloucestershire Hospitals NHS Foundation Trust (Acute Healthcare Trust), Cheltenham Borough Council benefit fraud investigation department, and the GP practice where the victim was registered at the time of her death.

5.0 DHR Panel

5.1 The DHR panel was made up of people who work in a relevant area of the focus for the review and local relevant support practitioners and professionals, including charitable organisations. The individuals who made up the panel for this DHR were from the following agencies:

Independent chair - University of Gloucestershire
Cheltenham Borough Homes:
Cheltenham Borough Council:
Gloucestershire Constabulary: Detective Inspector
Gloucestershire Domestic Abuse Support Services: Service Manager
Oakley Neighbourhood Project: Service Manager
Gloucestershire Hospitals NHS Foundation Trust:
Infobuzz:
Gloucestershire County Council - Adult Services:

6.0 Equality and Diversity

- 6.1 The panel considered issues of equality and diversity. All nine protected characteristics in the 2010 Equality Act were considered by the DHR panel and one in particular was found to have relevance to this DHR: that was disability.
- 6.2 Susan was considered to be suffering from ill health which was terminal. This fact was known widely by her friends and family, and Peter was aware of how fragile Susan's health was. Susan was not fit enough to receive the heart and lung transplant she had been assessed as needing.
- 6.3 The panel considered questions of vulnerability in this context, but it was stated by the NHS Trust and the Police that Susan would not have been considered 'vulnerable' according to their organisational criteria, based on national guidelines at that time (No Secrets 2000):

A person (over the age of 18) 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'

- 6.4 This issue was discussed at some length with the purpose of identifying how 'vulnerable' status may or may not have changed any services that Susan was receiving.
- 6.5 From the NHS perspective, even if Susan had been considered formally vulnerable, it was concluded that this would not have changed the care she was receiving.
- 6.6 From a police perspective 'vulnerable' or 'intimidated' victims could receive an enhanced service and there is now an obligation on police to identify such vulnerability or intimidation, but this was not a statutory obligation during the time span of this case. The *Youth Justice and Criminal Evidence Act 1999* defines vulnerable and intimidated witnesses as:

Vulnerable witnesses are defined by section 16 YJCEA (1999) as:

All child witnesses (under 18); and

Any witness whose quality of evidence is likely to be diminished because they:

- *are suffering from a mental disorder (as defined by the Mental Health Act 1983);*
- *have a significant impairment of intelligence and social functioning; or*
- *have a physical disability or are suffering from a physical disorder*

Some disabilities are obvious, some are hidden. Witnesses may have a combination of disabilities. They may not wish to disclose the fact that they have a disability during initial and subsequent needs assessments. Different witnesses on the autistic spectrum may have very different needs.

Intimidated witnesses are defined by section 17 YJCEA as those suffering from fear or distress in relation to testifying in the case. Complainants in sexual offences are defined by section 17(4) as automatically falling into this category unless they wish to opt out. Witnesses to certain offences involving guns and knives are similarly defined as automatically falling into this category unless they wish to opt out

Victims of the most serious crime, as set out in the Victim's Code, might also be regarded as intimidated. This includes close relatives bereaved by criminal conduct, victims of domestic violence, hate crime, terrorism, sexual offences, human trafficking, attempted murder, kidnap and false imprisonment, arson with intent to endanger life and wounding or causing gross bodily harm with intent.

Vulnerable and Intimidated Victims were defined under the Youth Justice and Criminal Evidence Act 1999, and this legislation was fully in force by July 2002 (National Archives accessed January 2016). So from this perspective Susan could have been considered as intimidated. She self-identified to police as an intimidated witness when she said she was too scared to testify as a result of domestic abuse and violence.

It was the Victim's Code which was enacted under the Domestic Violence Crime and Victim's Act 2004 which placed a responsibility on police to identify vulnerable or intimidated witnesses. This was in force by 2006 though there were no civil or criminal sanctions for non-compliance. The legislation was updated again in 2013 and 2015 but these updates are outside the span of this review.

6.7 Witnesses who have been identified as intimidated after 2006 would have been entitled to 'special measures' in court.

6.8 This issue is discussed further in the analysis of issues in sections 10.54– 10.56.

7.0 Family Background

- 7.1 Susan and Peter had two children. Both are now adult and there are two grandchildren. The family maintained close contact with each other and would meet regularly. Peter was a problem for all members of the family, and they all suffered from his controlling, violent and abusive behaviour. A genogram was provided but has been excluded for anonymity
- 7.2 There are complexities in the relationships between Peter and his children. There is a documented incident of him abusing one of his children from Gloucestershire Constabulary, and the NHS Foundation Trust, as well as Susan alleging this herself to Cheltenham Borough Council benefit and fraud investigation team. This reported incident of assault against the child is given as the reason for Susan finally living apart from Peter. It has also been reported by the police and Susan's family members that both children were, and still are, afraid of Peter.
- 7.3 In a letter from the Child and Family Service provided to this review, and written by a medical doctor after an examination of one of the children, there is clear acknowledgement the child was 'very frightened' by the arguments between their parents. It was also acknowledged that the child was 'terrified' that they would be taken away from Susan. It was advised in the letter that Susan and Peter should address the issue. Peter indicated on this occasion that his behaviour was problematic and that he would seek 'anger management' help. This never happened.
- 7.4 The family told the Review that Peter was a man of routine and would impose those routines on others, especially Susan.
- 7.5 It was alleged by Susan, that Peter had threatened and assaulted members of her family, in order to control her. There is evidence in testimony given to this review to suggest that the whole family were frightened of Peter and his violence. Family members reported to the Independent Chair that they had been threatened, assaulted, suffered criminal damage, and even been abducted by Peter over the years. All incidents related to control of Susan. There had been serious assaults and injury with weapons, even a machete, and threats with firearms, and this created a climate of fear where everyone was frightened of what Peter would do.
- 7.6 The fear was such that many of these incidents were not reported to police as the family observed that it was their belief, that on many occasions when the police were called, nothing was done.
- 7.7 There was a complicating factor in this dynamic and that was that Peter had a relative who was a serving police officer in the Gloucestershire Constabulary. Although there is no evidence to suggest that this officer in any way behaved in anything other than a professional manner, the family were concerned that Peter could find out if they had been contacting the police.
- 7.8 There were also problems at the trial with what were possibly conflicted loyalties mixed with fear. One of the adult children changed their decision during the trial, to give evidence against Peter which was of great importance to the prosecution case, and one adult child attempted to give Peter a character reference which caused this adult child some visible distress. Things were further complicated when neither adult child was considered vulnerable or intimidated, and so did not receive the special measures put in place to help such witnesses. A formal complaint was made against Gloucestershire Constabulary relating to this, but was not upheld. This created great division and friction within the family.
- 7.9 These are frictions all created by Peter and exacerbated by a lack of knowledge of Domestic Abuse in some of the agencies involved.
- 7.10 The immediate family of Susan were contacted by the Independent Chair and informed that a review would take place. When the criminal proceedings were completed the family were contacted again to invite their participation in the review.

- 7.11 As a result of the homicide and the family divisions, contact was made separately to Susan's adult children, and to the wider family via two different points of contact, using the Homicide Service, and the police Family Liaison Officer.
- 7.12 Susan's adult children at first declined the invitation to participate in this review. This was communicated to the Independent Chair through the Homicide Service. This decision was respected by the panel and no further contact was made with them until the Overview Report was completed.
- 7.13 When the report was completed, one of the adult children contributed to the review.
- 7.14 Other family members were contacted through the police Family Liaison Officer and they decided they did want to participate. The independent chair met with them on five occasions
- 7.15 The family were sent information about help they could receive from national charity AAFDA who help families with DHRs, and this information was included with the letter they received from the Independent Chair.

8.0 Chronological Sequence of Events

- 8.1 This chronological narrative of Susan's life is written taking consideration of information drawn from official files, organisational records, and personal testimony from Susan recorded in interviews and telephone call transcripts, and conversations with her family. When all these sources of information were collated, the chronology, which included health and other data, was a large document with much of the content having no direct bearing on the death of Susan. For this reason the chronology has been edited to provide information of relevance. This chronology in this section of the report is written in narrative form. The panel have highlighted some key incidents where they believe more robust intervention could have helped Susan.
- 8.2 The Terms of Reference set the timescale for this review as starting from January 1999, however it is important that some historical context is provided as the abuse of Susan and her family started much earlier. The following paragraph provides an overview and context and family gave information outside of the timespan set by the Terms of Reference:
- 8.3 Susan and Peter met when both were young people. They lived fairly close to each other in the same part of Cheltenham. Family state that Peter was violent and controlling from the very beginning. He did not like Susan having contact with anyone but him, and would threaten and assault family members if they tried to interfere with his control. There are serious incidents recounted of Peter threatening male family members with a gun, abducting one male family member in his car and using a shotgun to threaten him. Another family member was attacked with a machete and needed significant medical attention to his hand afterwards. The family said that the police would turn up when called, and warn Peter to behave himself, but it seemed to them it was dealt with in a casual and friendly manner. It appeared to the family as if Peter never had to face the consequences of his actions. The family say that quite early on they stopped calling the police as they felt nothing was ever done, and it made things much worse for Susan because nothing was done. Similarly, Susan stated that Peter would follow her, and if she spoke with anyone, he would approach that person afterwards and threaten them. He would tell people not to talk to her or be friends with her. It is this context, and a climate of fear, that dominated the actions of the whole family in dealing with Peter and Susan. The family state that Susan would allow Peter access to her and her life to protect her relatives and her children. Susan actually reported that she couldn't even bear Peter to touch her in the end, but felt she had no choice but to allow him in her home and life.
- 8.4 (Out of time scale) on the 26th February 1990 one of the children was seen by a doctor because of severe behavioural problems which included aggression and violence. The child was considered difficult to handle and frightening to other children. Susan reported she could not leave them alone even having to take the child to the toilet with her.
- 8.5 (Out of time scale) on 20th March 1990 one of the children was taken to casualty for an injury to the elbow sustained when Peter 'tried to prevent them falling out of bed'.
- 8.6 On 4th June 1990 (out of time scale) the child with behavioural problems was seen by a play therapist. Concerns were raised about their aggressive behaviour. It is also noted that the child would cut at their nails until they bled. This was the last appointment recorded as the child was not taken for follow up appointments. It is noted that the therapist did not feel that the child's issues would be gone, but closed the case.

- 8.7 On 8 October 1992 (out of time scale) Child was taken to a clinic after suffering unexplained abdominal and other pain. The clinician felt this was due to stress and tension.
- 8.8 **Key Incident:** (out of time scale) on the 15th May 1995 one of the children attended a medical assessment for behavioural and anxiety problems. The doctor noted that *'it was only when I saw (child) on their own that they were able to tell me that they were very frightened by the arguments mummy and daddy were having. These sound as though they include an element of physical abuse. (Child) is terrified that their mother will leave, and told me that in the last argument the father had said that the child would have to go into a children's home. (Child) was determined to stay off school the next day to make sure they stayed with the mother'*. In this consultation the medical practitioner notes that she had secured a promise from Peter to sign up for anger management classes. It was also said in this session that Peter and Susan had said to the children that 'they couldn't stop arguing straight away but would work on it'.
- 8.9 **Key Incident:** On the 19th February 2000 it is reported by police that Peter beat one of his children repeatedly with a leather belt. The injuries are described in official notes as causing welts and bruising to the upper back, lower back, backside and legs. It is documented that Peter's reason for beating his child was for punishment because the child had gone out without permission. Peter was arrested and charged with ABH. He was remanded to appear in court the following day. The complaint was withdrawn by Susan and the child after Peter volunteered to have private anger management classes. He did not attend any classes.
- 8.10 At the time, and as a result of this assault, Susan reported years of abuse to the police and it is documented that information and advice was given to her by them. It is not known what the advice was.
- 8.11 On 17th February 2001 one of the children was treated for injuries arising out of an incident which we have been asked to keep redacted from this report because it is of a private nature. This incident was serious enough that the child was referred for follow up to child and family services. This child explained that their parents had separated and that they were staying with their father, Peter. The child wanted to go and live with Susan but was told that because of Susan's housing circumstances and financial situation, this was not possible. The reality of the situation was reported to the panel by family that Peter would not allow Susan to have custody of her children. It is alleged in testimony from Susan also, that Peter made it impossible for her to have custody of the children at that time.
- 8.12 In the patient assessment of this child, there is a history of what are described as 'accidents'. The family were told that the child needed to stay at the hospital but the child was taken away by Peter against medical advice. On forming contact with Susan to inform her that there should be a visit with family services, the hospital was told that the child was with Susan at her home. The paediatrician involved wrote *'I do not see a protection issue as both parents involved and clearly concerned'*. There is no record of the outcome in hospital or family services records except that the appointment was not kept.
- 8.13 The agency records for this time are only partial and fragmented. What can be gleaned from various sources, including Susan's own testimony, is that there were times when she stayed in refuges, had panic alarms, and took out non-molestation orders. It is also alleged by Susan that Peter threatened to hurt the children and other family members if she did not do as she was told.
- 8.14 On the 6th December 2004 Police reported a 'verbal argument' between Susan and Peter. Susan reported that when she tried to call a taxi to leave from a meeting with Peter he grabbed the phone from her, pulled her hair and punched her in the side of the head. Susan reported to police that she was too frightened of Peter to pursue a complaint. This incident was closed by police as No Further Action (NFA). The officer reports that there were no visible injuries to Susan and as

such this was recorded as a 'common assault'. At the time there was no power for police to arrest for common assault. Susan was signposted to an advocacy organisation.

- 8.15 On 8th April 2005 Susan reported to police via a 999 call that she was receiving unwanted contact from Peter. At this point they had been separated for some years. She said she was receiving threatening text messages and telephone calls. Susan reported that she found the contact distressing and was frightened. Peter was to be issued with a harassment warning. However, this was not done.
- 8.16 Susan further reported in May and June 2005 that Peter was continuing to send messages. It is recorded on the 3rd June 2005 that police intended to issue the harassment warning which was still pending from April.
- 8.17 **Key Incident:** On the 17th June 2005 Susan reported to police that on the 7th June 2005, Peter had strangled her to unconsciousness. She said she woke to find him splashing water in her face to bring her round.
- 8.18 Susan was given a panic alarm as a result of this report and police originally classified this assault as attempted murder. It was later reclassified by detectives as an ABH which is a lesser assault.
- 8.19 Her allegation was corroborated by one of her adult children and a friend who said they saw black bruises covering her neck.
- 8.20 **Key Incident:** On the 20th August 2005 Susan activated her panic alarm and reported that Peter had tried to strangle her again, causing her nose to bleed. Susan had managed to escape the assault and run to her neighbour's home. Whilst trying to escape Peter had attempted to drag her back causing cuts and bruises to her knees, feet, elbows and hands. Susan was reported to be wearing 'baby doll' pyjamas and no shoes in some testimony. However, in other testimony from witnesses she was reported as naked.
- 8.21 No statements were taken from the neighbours at the time. Police state the neighbours refused to give statements, the witnesses say they weren't asked to give statements. Statements were given about this incident after the homicide in 2014.
- 8.22 Police reports show activity to try and arrest Peter with Susan's co-operation as a result of these incidents. The police report states that Susan is 'frightened to death' of Peter.
- 8.23 Police records from 15th September 2005 indicate further reports from Susan of harassment from Peter, and that he was making attempts to try and find out where she was living.
- 8.24 On the 16th September 2005 Susan applied for a civil non-molestation order and this was granted with a power of arrest attached.
- 8.25 On the 26th October 2005 a detective constable was tasked with investigating Peter. He made numerous attempts to arrest him without success. Peter is reported to have been staying in Thailand at this time. The detective reports that Peter's adult children were uncooperative, but that he considered that one of the adult children was frightened of Peter.
- 8.26 On the 15th August 2006 Susan called police to say that Peter was back in the UK.
- 8.27 On the 16th August 2006 Susan retracted her statement of assault when police visited her.
- 8.28 Peter was finally arrested on 20th August 2006 at the airport when he attempted to re-enter the UK.
- 8.29 **Key Incident:** After being interviewed under caution Peter told police that he had not attempted to strangle Susan but had pushed her. He did admit to sending harassing text messages. The interviewing officer said that he believed the assault amounted to a push, and that the harassment was a series of abusive text messages.
- 8.30 On the 18th October 2006 Peter was given a formal caution for Common Assault and harassment in relation to the two incidents involving allegations of strangulation.

- 8.31 On the 9th December 2006 Susan spoke with the local domestic violence agency GDVSAP after being referred by police. Susan spoke of continuing harassment from Peter on his return to the UK. GDVSAP advised that she keep a log of harassment and call them again should she require any help. Susan never called back.
- 8.32 **Key Incident:** On the 19th May 2007 Susan reported to police that following an argument, Peter had stolen her car keys and taken her car. He returned the keys later but would not tell her where the car was. Police state that 'due to circumstances' Peter was not arrested, nor a statement taken from Susan at the time. An appointment was made to take a statement at a later date. On the later date Susan retracted her allegation saying that if she continued with the allegation then her relationship with her children would be damaged.
- 8.33 On the 8th June 2007 Susan made an application for housing on the basis that she was a victim of domestic violence and homeless. She said she was living with her brother. Her claims of DV were supported by recorded contact with the police.
- 8.34 On the 29th June 2007 Susan was declared 'not homeless' by Tewkesbury Borough Council.
- 8.35 On the 4th July 2007 Tewkesbury Borough Council interviewed Susan and came to the conclusion that it was not clear whether she was a current victim of domestic abuse. Susan became distressed at this time and tried to retract her claim that she was a victim of domestic violence, because it seemed to her that this claim was actually getting in the way of her application. She said she was homeless due to financial difficulties. She also objected strongly to being investigated by Tewkesbury Borough Council.
- 8.36 On the 23rd October 2007 Susan reported to police that Peter was outside her flat. No offences were disclosed according to police records most of which are no longer available.
- 8.37 On the 28th February 2008 Susan said to her clinical care specialists that she was living with her brother and his wife. Susan was referred to the Heart Failure Nurse Community Team.
- 8.38 On the 14th April 2008 Susan requested support from Adult Services of Gloucestershire County Council with her finances, and also requested help from a social worker because of housing, money and health problems.
- 8.39 During the next couple of months it seems that Susan received lots of bad news about her health. She was told by her cardiologist that she was not suitable for the heart and lung transplant that she needed. She also reported depression and what are described as 'ongoing issues with her ex-husband'.
- 8.40 **Key Incident:** On the 28th September 2009 Susan reported to police that Peter had been into her home and stolen her mobile phone. He had secreted it in a newspaper and left. She reported that this action was all part of control being exerted over her by Peter. She told the officer she had moved around a lot because of domestic abuse from Peter.
- 8.41 By the 9th October 2009 Peter had not been located and Susan withdrew her complaint, but said she wanted him spoken to by police. Peter was spoken to on the telephone about the theft, but denied it.
- 8.42 On the 15th October 2009 a civil non-molestation order was granted in court. Police state that the order was discharged at a hearing on the 9th December 2009, but there are no records which tell why this happened.
- 8.43 On the 16th March 2011 Susan made a housing application based on her medical needs. Her condition was described as stable, but terminal. Her current private landlord would not allow her to make changes to the property to help with her condition.
- 8.44 On the 15th June 2011 Susan contacted police and reported that whilst she was on holiday for two weeks, that Peter had been staying in her home and on her return was refusing to leave. Peter was taken home and it is reported that no offences were disclosed.

- 8.45 Between August 2011 and October 2011 Susan was pursuing her application for housing as she was finding day to day living was getting more difficult. She was assessed as suitable for sheltered housing. A benefits review was also carried out.
- 8.46 **Key Incident:** On the 22nd October 2011 Susan reported to police that Peter was refusing to leave her home and threatening her life. Susan said she had gone to her sister-in-law's house to get away from him and that she was frightened he would find out where she was and cause problems for her family. The police narrative from the attending officers gave no hint that they considered she was in danger. One officer described Susan as intoxicated, and as giving mixed messages to Peter. It is stated that this was *not a domestic incident* in the log. Susan and Peter were both warned about their behaviour. No risk assessment was performed and no action was taken. It does not appear that a history of domestic abuse was considered. It is reported that the suggestion that Susan was drunk and slurring her words is not supported by the telephone recording. It is stated by police however, that Susan could have become intoxicated between the phone call and police attendance. It should be noted here that intoxication should not be considered an indication that the victim's allegations are untrue, or that the level of risk is diminished.
- 8.47 **Key Incident:** On the 19th January 2012 at 2247hrs Susan made a phone call to the Gloucestershire Police contact centre. She requested a visit from the Domestic Violence team. She spoke to the officer about threats and abuse she had received that evening from Peter and told of locking herself in and being terrified. She said she just wanted the abuse to stop. She said she had lost faith in the police to do anything, and that Peter always made it look as if she was making up the abuse, and she felt that police believed him. Susan cried during the call and was clearly worn down and frightened. She said she was a prisoner. The officer appeared sympathetic but asked her if she was 'encouraging' Peter to keep contacting her. The officer then told her that if she had any further problems she should ring 999 and that an officer would call on her after the next day. No-one attended at that time to speak to Susan.
- 8.48 An officer attended the next day and Susan was assessed as Standard Risk and comments from police that Peter was 'invited' into her home suggest a fundamental misunderstanding of domestic abusers and domestic abuse victims. No DASH form can be located for this visit.
- 8.49 On the 7th May 2012 Susan moved into sheltered housing.
- 8.50 On the 2nd August 2012 Peter reported Susan for housing benefit fraud
- 8.51 **Key Incidents:** On the 7th January 2013 Susan was interviewed under caution with reference to benefit fraud.
- 8.52 She was interviewed again on the 6th February 2013
- 8.53 She was interviewed again on the 22nd February 2013
- 8.54 During these interviews Susan talked of the abuse and violence from Peter, and his financial abuse too.
- 8.55 **Key Incident:** The fraud investigation prompted the benefits office to stop Susan's housing benefit. She could not work because of her ill health, and was thus threatened with eviction and homelessness. This created great stress for her in the last months of her life and her fears and anxiety were not always recognised by any of the agencies involved.
- 8.56 Peter had instigated the fraud investigation by alleging that Susan had money from the sale of their marital home which she had not declared when claiming benefits. Susan claimed in interview under caution to the investigating agency that Peter controlled the money she had, and that she regularly gave lump sums to him. She did not know it was Peter who had made the allegations.

- 8.57 Peter inadvertently implicated himself in fraud, as he had received a sum of money from sale of the marital home which he had not declared. It appeared that towards the end of Susan's life the impending investigation and its consequences were resting heavily on her. She had consulted her GP about the anxiety, depression and panic attacks she was experiencing, and talked of her fear over the investigation. There is no reference at all in the GP notes of domestic abuse.
- 8.58 It seems also that Peter tried to retract his allegations on realising that he too would be investigated. He made calls from Susan's home asking if anything could be done to stop the investigation. It seems that the impending fraud investigation was creating stress, albeit self-inflicted, on Peter too. On the 7th May 2013 Peter was invited to an interview under caution to be held on the 14th May. He did not attend.
- 8.59 On (date removed for anonymity) 2013 Peter was in Susan's flat. Susan had reported that he was gaining access by ringing the communal bell and being let in by her neighbours.
- 8.60 At some point during that day or evening Peter hit Susan in the side of her head, then put his hands around her throat and squeezed, the post mortem report suggests that he would have squeezed for at least ten seconds. He killed Susan.
- 8.61 It is alleged that he may have stayed overnight in the flat with Susan's body.
- 8.62 Susan's body was discovered by police some three weeks later. Her body was lying in her bed, hidden by a duvet and pillow.
- 8.63 After killing her, Peter took her car and sold it, and tried to make everyone believe that she was still alive. He had plans to flee the country to try and evade prosecution for Susan's murder.

9.0 Trial

- 9.1 The trial was held at Bristol Crown Court. In all the trial was started three times due to problems not completely unrelated to Peter's abusive and violent nature.
- 9.2 The prosecuting barrister presented a case which represented Susan as someone who could not live without Peter, it was said 'she couldn't live with him, and couldn't live without him'. They told the jury that Susan chose to let Peter into her home and her life and sometimes gave mixed messages. At one point in the first trial Susan was described as possibly 'foolish' for 'allowing' contact with Peter. This is an unfortunate representation of Susan's life and does not demonstrate the fear Susan had of Peter, his brutal violence against her and her family, or the lack of choice she had about his presence in her life.
- 9.3 Forensic narratives are powerful rhetorical tools and have an enduring presence in the official record of a domestic homicide. It is important therefore that domestic abuse is fully understood by prosecutors, and the constraints it places on victims of it properly articulated in the narrative to aid in better understanding for the future, and to help prevent domestic homicide.
- 9.4 The prosecution case put together by Gloucestershire Police relied heavily on circumstantial evidence as there was little forensic evidence, and no direct witnesses to the strangulation. It was also complicated by Peter's complete denial of any involvement and the reluctance of some witnesses to events after the homicide, to give evidence in court. However, the case was meticulously investigated and the subsequent chronology of circumstantial evidence was of sufficient strength to convince the jury of Peter's guilt.
- 9.5 Peter was found guilty of murder and sentenced to life with a tariff of sixteen years before being eligible for parole. The jury took less than three hours to reach a verdict.
- 9.6 The Judge said to Peter 'you displayed jealousy, possessiveness and a need for control...but your anger with her was such that you intended to kill her. Even if you didn't, she was a slight, frail and vulnerable woman, who suffered from heart and lung problems'

10.0 Analysis

- 10.1 *'The key question in evaluating the service response is whether it addresses the perpetrator's violence and whether it increases the safety of the women and children living with domestic violence as well as responding to the separate needs of the children and their mothers'* (Stanley and Humphreys 2006).
- 10.2 The chronology and supporting documents have provided a good overview of Susan's life. There are consistencies in agency responses to Susan which cannot be separated from her lack of faith and trust in the help available. Forty years ago there was less knowledge and training in domestic abuse and coercion and control, but this review has found that attitudes were remarkably similar across agencies and across the time span. Specifically, agencies did not appear to always recognise domestic abuse, and even where they did, they did not appreciate the high risk characteristics present.
- 10.3 It should also be considered that even if policy and practice was different at the beginning of this story of domestic abuse, that the victim and family members will have memories of how those policies worked, which they carry to their present perceptions of public sector agencies. Because the family, and the victim, considered they experienced a lack of action from agencies, this inhibited them in continuing to seek action, and a lack of trust that the police would act effectively, made them frightened to stand up to Peter.
- 10.4 All agencies should consider that historical policies and practices may have current effect and approach domestic abuse victims with that knowledge in mind.** It is not enough to merely acknowledge that things are different now; this must be considered in all dealings with domestic abuse victims.
- 10.5 It has been explicitly stated by family members that they believe that if something had been done earlier then the tragedy may have been avoided.
- 10.6 As there was such consistency across agencies, this analysis has considered agency responses together, rather than separately, and written as a chronology to enable a fuller picture to emerge.
- 10.7 This chronology began with documenting some of the medical records of one of Susan's children. It can be clearly seen that the child was presenting with significant behavioural problems, which are documented as being related to domestic violence by one doctor and that physical symptoms were related to stress and tension by another doctor. It is acknowledged that these records are over twenty years old and it would be easy to assume, that these clear indications that intervention might be needed, would be picked up by clinicians now. The panel did consider this very problem and as will be further discussed, we were not totally convinced that clinicians from many specialisms, always recognise the serious nature of domestic abuse, even now. This includes Paediatricians and General Practitioners. Notwithstanding that the reports are historical, it should be considered that there are still gaps in provision for children who are witnessing, or who are direct victims of, domestic abuse.
- 10.8 In these records, at this point, Peter acknowledges that he has a problem which he identifies as being his bad temper. He agrees, in response to problems with his child, that he needs anger management classes. Though he never takes these up, it is a clear point where intervention could have been manipulated with Peter's consent. He appeared more willing to acknowledge his behaviour in this context, than in response to his treatment of Susan. The next stage in the chronology is another time which raises the same learning point.

- 10.9 **Key Incident:** On the 19th February 2000 it is reported by police that Peter beat one of his children repeatedly with a leather belt. Again here, in response to a problem with his child, Peter agrees to attend anger management classes. Again he does not independently follow this up and does not attend any classes. Agencies do not follow this up, and police agree to suspend any potential prosecution, apparently because the complaint was withdrawn. This is a clear point at which intervention could have been crucial for Susan and her children. The intervention could have come from either the police or the hospital, or both. There does not appear to be any link between the medical records of this child, which link the issue of them living with domestic abuse, and then being subject of a serious assault. Neither do police continue with a prosecution for such an assault on a child.
- 10.10 On 17th February 2001 one of the children was treated for an incident which we have kept redacted from this report because it is of a private nature. This is another point where an intervention could have been helpful. However, as noted, in the patient assessment of this child, there is a history of what are described as ‘accidents’, but the paediatrician involved wrote ‘*I do not see a protection issue as both parents involved and clearly concerned*’. If this incident had been linked to the prior known history of abuse, and the previous behavioural issues, there is a possibility that the paediatrician could have come to a different conclusion, but this is speculation. However, given the child’s age and the nature of the incident, and the fact that the child was taken from the hospital by Peter before being properly discharged, a referral to children’s services should have been followed up. This incident appears to be a pivotal time when intervention could have had an impact. There is concern noted in records that there had been numerous visits to the hospital by this child, and it was known by other agencies that there had been an injury caused by an assault by the father. The conclusion by the paediatrician that there was no concern is not helpful. Discussions on this aspect by the panel revolved around whether a similar decision could be made by a paediatrician now. It was concluded that due to the hierarchies in NHS staffing that a paediatrician may not be challenged about their decisions, and there is no automatic referral in such cases to children’s services. This may then be a training issue for paediatric staff in hospitals.
- 10.11 It was also considered that specialist services and help for children in families where there is an abusive parent are limited. In consideration of this point two key problems were considered. The first is a concern articulated by Susan’s family that the children became facilitators for the abuse against Susan. Not only did Peter threaten to hurt them, they also behaved in a way which placed significant pressure on Susan to keep the family together. The family told of Peter’s various methods of control of the children. For example, Peter would buy extravagant gifts for them without Susan’s knowledge, and then take the gifts away when they displeased him. One child was even bought a pony which was a lever for many things. The family said that on at least one occasion when the police went back some time after a complaint, the children would be used to ‘emotionally blackmail’ Susan to withdraw her statement. This review cannot say why or how the children were used to facilitate access and abuse, but fear and conflicted loyalties are clear possibilities. The second consideration is the trauma suffered by those children witnessing abuse and violence towards a parent. There is a specific need identified for children’s support services.
- 10.12 The panel is aware that there is some county-wide commissioned support for children experiencing domestic abuse through an arts-based programme, but whilst this is valuable, this provision does not provide specialist support to equip children with the tools to process and cope with what they are witnessing.

- 10.13 The panel sought information about potential services and/or schemes available for children witnessing or suffering domestic abuse, especially at a younger age, between seven and twelve. There are programmes and services available including nurturing circles, inclusion of domestic abuse in the school curriculum, and the PINK (People In The Know) framework. Professionals in schools reported that the nurturing circles were particularly helpful for all sorts of problems, and professionals from local services reported that they have the training and the programmes to run, but have in recent years suffered from a lack of funding.
- 10.14 In terms of the chronology the aforementioned incidents would appear to be the last point at which domestic abuse is reported to health agencies as a problem for the children.
- 10.15 The next documented incidents are with the police, beginning with a report of an assault on Susan by Peter in December of 2004, by which time they had separated. The assault is described as a verbal argument, despite an allegation of violence. It is stated in the records that Susan said she was too frightened of Peter to pursue a complaint. The police state that there were no visible injuries so now power to proceed with a s47 assault charge for which there is a power of arrest. At this time there was no power of arrest attached to the offence of common assault. The police could still have reported Peter for a common assault even if they did not arrest him, but they made the decision to take no further action (NFA). However, they did tell Susan about the local domestic abuse service. This incident log tends to support the family assertion that Peter's behaviour was not robustly challenged by police officers.
- 10.16 In April 2005 Susan called police again via a 999 call and reported harassment from Peter. She told police of threatening messages and clearly stated that she was frightened. It may not have been common knowledge at this time, but low level harassment and repeated threatening messages are an indication of risk in domestic abuse. However, the police did say that Peter would be issued with a harassment warning, although this was not done.
- 10.17 Susan further reported in May and June 2005 that Peter was continuing to send the messages. Police said they would issue the harassment warning pending from the previous reports. It is not known why this was not done as there are no records which document this. However, it may have appeared to Susan that the police were not taking her complaints seriously. The danger for Susan was escalating at this point, and more high risk behaviours were being reported to police.
- 10.18 **Key Incident:** On the 17th June 2005 Susan reported to police that *on the 7th June 2005 Peter had strangled her to unconsciousness. She said she woke to find him splashing water in her face to bring her round.* After this report the police are clearly giving the risk to Susan more consideration and she was issued with a panic alarm. At first, the report was considered as possibly an attempted murder, but after being considered by detectives it was decided that the evidence better fit a lesser assault which was a s47 ABH. There was black bruising noted to her neck by witnesses and there was clear risk noted by police. There is a power of arrest attached to a s47 assault but this was not used in this case. It is also noted that even though the offence of attempted murder may be difficult to prosecute because of the intent aspect which must be proved, better evidence gathering may have given more choices in charging options. It is acknowledged by police and prosecutors that ABH is often charged because the presence of bruises is easier to 'prove'. Simple photographic evidence will support this charge. Strangulation assaults are however, extremely high risk and are known to predict future homicide. In many States in the USA strangulation assaults must be charged as a felony (serious offence), rather than a misdemeanour (less serious offence), so their high risk nature is recognised in the Criminal Justice System. Evidence gathering for more serious charges can be improved through training in interviewing witnesses and victims in the special characteristics of a strangulation assault. There are things which happen to the victim which can be documented and even corroborated by clinicians. Even though this

strangulation assault was ten years ago, police and CPS have reported to this review that they are still charging most of these types of assault as s47 ABHs. It is possible that a s21 strangulation assault charge may also be considered. Police could also consider special strangulation evidence gathering aids to help in this process.

- 10.19 **Key Incident:** Things continued to escalate and in August 2005 Susan activated her panic alarm and reported that Peter had tried to strangle her again, such was the severity of this attack it caused her nose to bleed. The assault continued outside the house as Susan attempted to get to safety. In addition to the panic alarm activation, the police were also called by Susan's neighbours. This incident has raised different accounts of police action. The neighbours claim in speaking to Susan's family, and in a statement to the murder enquiry, that they were never asked to provide statements in relation to this incident. The police officers state that the neighbours refused to give statements. The fact is that no statements were taken from the neighbours. It is also alleged that Susan was naked when she ran for help, and that she was in this state of undress when her daughter arrived. Susan said that she was so ashamed that her neighbours had seen her like this that she wanted to move away. Police state they made numerous attempts to arrest Peter as a result of these assaults, and also state that Susan was 'frightened to death of Peter'. These are now known to be very high risk indicators for future homicide – the harassment, the strangulation assaults, the previous violence and the terror of the victim are noted in international research to be risk markers. There were at least two officers at the second allegation of assault who could have given statements as to the state of the victim - her state of dress, her emotional state, the injuries to her feet, elbows, hands and knees, the blood on her clothes/body and the blood left on the bedding belonging to the neighbours. In analysis it must be considered that intimidated witnesses, police witnesses, and other evidence could potentially have been given more attention, especially as there was already a panic alarm in place and a high risk history according to police records.
- 10.20 The commonly used Risk Identification Checklist now in use in Gloucestershire, is the DASH Risk checklist, which was not in use in 2005. This checklist was in general use across much of the UK in 2009. However, it appears the high risk markers are still not always recognised by agencies in general, and more awareness is needed so that they can be identified and responded to adequately. Susan continued to report harassment from Peter, and she managed to obtain a civil non molestation order, but the police failed to locate him for arrest. By October Peter is reportedly in Thailand. Police note in records at this time that the children also seem frightened of Peter and are uncooperative. These comments tend to suggest that police are recognising the potential that these witnesses are intimidated by Peter.
- 10.21 In August 2006 Susan called police to say that Peter was back in the UK and police visited her to obtain a new statement about the assaults for which he was wanted. Family state that Susan thought she was being asked to make the complaint all over again and this frightened her. The family state that because of this she said she did not want to make the complaint, they feel this was understood by the police as a retraction, and may well have been articulated as such by Susan at the time.
- 10.22 The family state that at this time Susan had been living a much more relaxed life. She did not have the constant harassment from Peter as he was in Thailand, and she had freedom to see her family and friends. When she found out that Peter was coming back, they state that she suddenly changed and became very fearful. They say this was compounded by the police visit.
- 10.23 Peter was finally arrested on 20th August 2006 at the airport when he attempted to re-enter the UK and was questioned under caution about the strangulation assaults. This is another key opportunity for intervention. Peter said in interview that he had only pushed Susan and had not

tried to strangle her. This is in contradiction to the evidence where it is clearly stated that black bruising was noted on Susan's neck. Peter admitted to harassment however, possibly because there was evidence of that harassment in the text messages. Police decided to give Peter a formal caution for common assault and harassment. There was evidence available to support a more serious charge for these assaults than common assault, which sits at the bottom of the hierarchy of assaults. According to witnesses there was evidence for at least a s47 ABH if statements and photographs had been taken.

10.24 Even after this Peter continued to harass Susan. After being referred by police to GDVSAP a local domestic abuse support agency, Susan was advised by them to keep a log of the harassment. She never went back to this agency, it is not known why.

10.25 The harassment continued into 2007 and Susan made a report to police that Peter had stolen her car. Police did not take a statement from Susan at the time, and he was not arrested. An appointment was made to take a statement from Susan at a later date. It was at this later time that Susan retracted her complaint. Looking back at this incident a couple of things are notable, first that the report of a stolen car, with an identified offender, perhaps should have been treated more seriously and it is probably the 'domestic' nature of the incident which could have been the reason for the downgraded response. However, Susan was repeatedly experiencing her complaints and distress treated as non-serious by agencies. Secondly, she had a true belief, and this is recorded, that she felt there was nothing she could do to manage the danger presented by Peter. She felt it was actually quite dangerous to pursue complaints when nothing was happening. It was safer to withdraw the complaint. In this incident, it is perhaps clear that the danger was not recognised. Had the police attended and taken a statement immediately there may have been another opportunity to get Peter into custody and a chance to respond more robustly to the situation. It may be advisable that domestic abuse related incidents are responded to quickly, and statements taken quickly along with gathering of evidence to support the complaint. Susan also said, in relation to this incident, that she was withdrawing her complaint because she was worried that her relationship with her children would be damaged. Statements like this reveal the complex pressures placed on victims of domestic abuse which reduce the choices they have to take action or help. Where children are used as a weapon, and in addition those children are not receiving support, abusers have increased power to control everyone in the situation.

10.26 On the 8th June 2007 when Susan made an application for housing on the basis that she was a victim of domestic violence and homeless, another opportunity for intervention was possibly missed. Susan was again asking for help. There was a history recorded with the police, and with health authorities which would support her claims. It is unfortunate that the housing agency involved decided that she was not 'homeless', and they also decided that it could not be proved that she was a current victim of domestic abuse. Records suggest that Susan became very distressed and frustrated at this conclusion. In fact records suggest that Susan was considered difficult in her response. When the full picture is put together it is easy to understand why Susan was so very upset and frustrated. The historical documentation does suggest a lack of understanding in the agency of domestic abuse. Housing was a recurring problem in Susan's life. Housing was used to control and abuse her. Peter made it impossible for her to live in, or sell the marital home. This meant that Susan was, in her own words, 'in a catch-22 situation'. When her health is considered in this context and her inability to work, her housing problems were clearly serious. She lived with her brother for two years, unable, because of Peter, to have her own home. She was apparently given poor advice to not declare her part ownership of the marital home in order to qualify for housing, and this created more problems for her.

- 10.27 Susan does have contact over the next couple of months with police and health agencies. Her health was fragile and she was asking for help with her finances, housing, health, but also 'ongoing problems' with Peter.
- 10.28 The next Key Incident recorded, occurred in September 2009 when Susan reported to police that Peter had been into her home and stolen her mobile phone. Again she reported the domestic abuse to the officer but Peter was only spoken to on the phone by police about the theft and Susan ended up withdrawing her complaint again.
- 10.29 Susan did at this time manage to obtain a civil non-molestation order. It was however discharged not long afterwards, but no documentation exists to say why. It is clear that in taking out a civil order that Susan was trying to manage the situation, and manage Peter's control. There is no agency supporting her, and she was still trying to protect her family from him. Her health at this time was getting worse, and family report that she was very frightened that she did not have long to live.
- 10.30 By June 2011 Susan had her own accommodation but Peter was still harassing her. She contacted police to report that he would not leave her flat. Police did attend but state that no offences were disclosed. These problems are compounded by the fact that on numerous occasions police approached calls for help or service only from the perspective of identifying criminal offences. It is often said that there were 'no offences identified' as an explanation for no further action. Police have a wider safeguarding responsibility which extends beyond identifying criminal offences. This is at least protection of life. Even where police were failing to identify criminal offences, they, and other agencies, could have been more pro-active in safeguarding Susan and the children.
- 10.31 At this point in time the DASH risk assessment checklist was in use but there is no record that a risk assessment was done. Given the history in this story, a risk assessment, if done, may have revealed the danger that Susan was in. This is especially so when she called police again when he wouldn't leave her flat in October 2011, but also claims that he was threatening her life. This was a clear missed opportunity for intervention. Susan clearly states she is frightened that Peter will harm her family; she also states he has threatened her life. This incident was not treated as serious by police. Police state in their report that Susan was 'intoxicated' and was giving 'mixed messages' to Peter, and that this was not a domestic incident. There are two clear issues here, first; even if Susan had been intoxicated (though this is not supported), this does not mean a victim is untruthful, neither does it reduce the risk to the victim. Secondly, the clear danger presented to Susan was not recognised, and the opportunity for a proper risk assessment interview was not taken. The family were particularly upset by this assessment of the situation and were very clear that they would like it to be in this report that intoxication should not mean withdrawal of proper service.
- 10.32 Susan had clearly reached a very low point in January 2012 when she called the Gloucestershire Constabulary Contact Centre. In this call, which was played to the Independent Chair, Susan asks for a visit from the domestic violence team. She disclosed that she was suffering violence and abuse, but that the police just kept believing Peter. She was crying and distressed. She said that no matter what she did nothing stopped him and that she considered herself a prisoner. Although the officer was sympathetic he clearly did not understand the seriousness of the situation, and even asked if she was 'encouraging' Peter. It is often the case that victim behaviour can be constructed as 'encouraging'. If we just briefly look at Susan's behaviour where she spent time with Peter, he was in her home, and he was always in her life, the simplistic conclusion might be she wanted him there. However, Susan was clear over many years that she couldn't get him out of her life, and that she was scared to death of him. Abusers maintain control through fear but this was not recognised by agencies. It was recognised by her friends and family. This phone call

raises a number of issues which are relevant to the analysis of this case. The officer was sympathetic, but sympathy on its own is not helpful, and sympathy does not make a victim safe. Susan's safety strategy was to do whatever Peter told her to do, and to let him control her. She was just too scared to do anything else. She was not getting support or safety advice or help from the police or anyone else. She was probably right to appease Peter, as the criminal justice system was not helping her. No one attended to speak to her that night.

- 10.33 An officer attended the next day and completed a DASH risk assessment. Susan was assessed as Standard Risk. *There are three possible risk levels which come from such an interview, standard, medium and high. Standard is the lowest assessment.* Comments from police that Peter was 'invited' into her home suggest a fundamental misunderstanding of domestic abusers and domestic abuse victims. No DASH form can be located for this visit so it is not known how the assessment as standard risk was reached. This is a clear training issue. Susan was a very clear high risk victim. As we do not know how the RIC was filled out we cannot say whether Susan just failed to disclose the extent of the abuse, or the officer did not understand or ask the right questions. In hindsight we can say that she was high risk, so why didn't the information get into the risk assessment? It could be lack of interviewing skills, lack of knowledge of domestic abuse, failure to take into consideration the fear directing the responses, or a number of other factors.
- 10.34 When Peter reported Susan for benefit fraud the danger to her started to escalate. She was interviewed under caution three times with reference to this. These interviews contained disclosures of abuse. It was known to the interviewing council officers that the abuser was the person who reported the fraud, but this was not known to Susan. The fraud investigators were told in interviews under caution about the abuse and violence. Whilst it is recognised by the panel that the investigation was not completed at the time of Susan's murder, the investigators made no comment in their IMR that Susan's complaints would have had any impact on the decisions made about the fraud. This may well be a policy issue which may need addressing by all fraud investigation departments, as financial abuse is a significant factor in much domestic abuse.
- 10.35 This chain of events prompted more unfortunate decisions which further distressed Susan. It was decided to stop Susan's housing benefits and letters which threatened eviction were sent to her. This was at a time of failing health and an inability to work.
- 10.36 The danger escalated seriously when Peter began to lose control of the situation and was informed that he would also be investigated for fraud.
- 10.37 Peter inadvertently implicated himself in fraud, as he had received a sum of money from sale of the marital home which he had not declared. It appeared that towards the end of Susan's life the impending investigation and its consequences were resting heavily on her. She had consulted her GP about the anxiety, depression and panic attacks she was experiencing and talked of her fear over the investigation. There is no reference at all in the GP notes of domestic abuse. Susan was very vocal in telling agencies about her problems with Peter, and it seems the only agency she did not disclose to was her GP surgery. We do not know if it was not discussed or was discussed but not put in the notes. The Surgery did not have this information.
- 10.38 It seems also that Peter tried to retract his allegations on realising that he too would be investigated. He made calls from Susan's home asking if anything could be done to stop the investigation. It seems that the impending fraud investigation was creating stress, albeit self-inflicted, on Peter too. On the 7th May 2013 Peter was invited to an interview under caution to be held on the 14th May. He did not attend. It is well documented in much research that people who commit domestic abuse or violence which ends in homicide, are often controlling personalities who at the point of the homicide, had lost control of the victim or their lives in some way.

- 10.39 On (date removed for anonymity) 2013 Peter was in Susan's flat. Susan had reported that he was gaining access by ringing the communal bell and being let in by her neighbours.
- 10.40 At some point during that day or evening Peter hit Susan in the side of her head, then put his hands around her throat and squeezed, the post mortem report suggests that he would have squeezed for at least ten seconds. He killed Susan.
- 10.41 It is alleged that he may have stayed overnight in the flat with Susan's body.
- 10.42 Susan's body was discovered by police and relatives on the (date removed). Her body was lying in her bed, hidden by a duvet and pillow.
- 10.43 After killing her, Peter took her car and sold it, and tried to make everyone believe that she was still alive. He had plans to flee the country again to try and evade prosecution for Susan's murder.
- 10.44 There are many high risk indicators in this case which have the potential to predict homicide. For example some of the most dangerous indicators are: Threats to kill, strangulation (or threat to life) assaults, sexual violence, coercive control, deep fear and intimidation in the victim. Stalking and harassment are also an issue in this case, but all these markers appeared to be largely invisible to agencies dealing with Susan. The family told of significant and high level stalking, some of which was reported to the police. For example, following her and then threatening anyone who spoke with her; taking her mobile phone; gaining covert access to her home; threatening and assaulting people behind her back to keep them away from her, and many more behaviours. These behaviours suggest that Susan was high risk for homicide and this is a clear training issue.
- 10.45 Some individual officers and employees of other agencies spoke to Susan with sympathy, but consistently, nothing was really done about the abuse and violence. Police, whilst often showing a sympathetic response, were not successful in prosecuting Peter or giving real support to Susan to ensure that prosecution was a safe option for her or her family. Her health carers, including GPs and community nurses, also sympathetic to her numerous problems, do not record any disclosures from Susan, neither is it recorded whether they asked her about domestic abuse. Housing officers were often sympathetic, but did not offer a robust housing plan for her when she disclosed the abuse. It is also apparent that the seriousness of the abuse was not considered in the response to Peter's accusations of fraud by Cheltenham Borough Council's fraud investigation department. Susan only ever contacted domestic abuse services once and never went back.
- 10.46 It seems that although agencies showed some sympathy, they did not offer a way out, or a way of making Susan safe. Also that sympathy did not mean they took her seriously. No-one really seemed to believe her life was in danger despite the numerous high risk characteristics in this case. This is clearly a training/awareness issue coupled with a lack of strong organisational policy.
- 10.47 It is consistent across agencies that the abuser's behaviour attracted little attention. In this case there was some evidence to suggest that Peter did not always observe warnings from police, or follow instructions in civil non molestation orders. However, there was also some evidence which suggests that he did not like the attention of authorities. For example, he tried to retract his accusation of benefit fraud when he realised he had implicated himself, he also tried to avoid police attention by going to Thailand, and he tried to manipulate police officers to avoid being considered an abuser, these behaviours suggest that a robust intervention could have had some effect. This includes the real threat of prosecution. This was not always followed through, and the rationalisation is often made in this case that there was insufficient evidence to continue. A dedicated domestic violence court staffed by experienced professionals may have given police and prosecutors more confidence that a conviction could be achieved, or given the victim

confidence that the abuse she suffered was not acceptable to society and the criminal justice system.

- 10.48 Where Peter was getting away with abuse he continued, where he was not, he fled.
- 10.49 There was not a consistent message given to Peter that his behaviour was unacceptable. He was getting away with it.
- 10.50 Susan's life was dominated by Peter and his need to control her. Certainly his actions were key in what happened to Susan in the last year of her life. Not only did he physically abuse her and control her daily activities, he exacted revenge on her through threats to her and her friends, and the allegations he made about her financial behaviour which resulted in a fraud investigation.
- 10.51 There was some considerable discussion with the panel on the subject of Susan's particular vulnerability. There are various definitions of vulnerability and organisations will adhere to those definitions which are relevant to their business.
- 10.52 The panel considered whether certain organisations could have recognised Susan's vulnerability and whether that might have changed any services she did or did not receive.
- 10.53 The definition of vulnerable used by the NHS Trust did not fully fit Susan's circumstances given the information at the time, in hindsight it could be considered that she did fit the definition. However, it is not necessarily the case that had she been considered vulnerable that this would have changed the services she was receiving in respect of domestic abuse. This is especially the case where health professionals did not appear to have disclosure of domestic abuse from Susan, or had not recorded it.
- 10.54 The definition of vulnerable used by the police is similarly unclear, but Susan could have been considered as intimidated with reference to national guidelines. Domestic abuse victims who retract statements, and specifically say they are retracting because they are frightened, would now be considered as intimidated.
- 10.55 The *Code of Practice for Victims of Crime* (Office for Criminal Justice Reform 2005) now places an obligation on the police to identify vulnerable or intimidated victims and to provide them with an enhanced service. Where vulnerable or intimidated victims are also witnesses, the code obliges police to explain the special measures set out in the Youth Justice and Criminal Evidence Act 1999 to them. The *Witness Charter* (Office for Criminal Justice Reform 2007) sets a similar standard for the police in respect of all witnesses.
- 10.56 The guidance may or may not have had an impact on the service Susan received, but recognising and responding to victims who are too scared to pursue complaints with adherence to the guidance is now considered good practice. We are cognisant of the fact that that prior to 2006 police would not have had any obligation to recognise Susan as intimidated, and that from 2006 to 2013 the code was voluntary.

11.0 Good Practice and Early Recommendations

- 11.1 At the very first meeting the panel considered if there were any recommendations which should be made quickly, and before the end of the process of the review. This was to efficiently and quickly implement any process which could help save lives.
- 11.2 The panel considered that it was of importance that local agencies recognise the significance of strangulation or choking attempts when they happen in the context of domestic abuse. Research was considered which showed a correlation between such assaults and future homicide.
- 11.3 As a result all panel members agreed to share this information with their agencies so that reported choking, drowning attempts, or strangulation could be considered in future cases of domestic abuse and be responded to as a serious and high risk behaviour.
- 11.4 This review also recognises that a strangulation assault is not just an indicator of future serious assault, but is a serious assault in itself. Strangulation assault should be considered to include other life threatening assaults such as any choking, smothering, or attempts to drown the victim.
- 11.5 It should also be noted that Gloucestershire Constabulary have developed procedures and policies since this homicide which are considered good and effective practice outside of the force area.

12.0 Conclusions

- 12.1 Susan's case reflects the experiences of many victims of domestic abuse in the sense that she experienced what might be termed 'classic' *high risk* abuse and control. It could also be said that she experienced many of the historically identified problems with accessing services and help. Susan did disclose abuse, but at the time of disclosure her complaints were not always recognised as serious. There appeared to be a lack of knowledge about domestic abuse and the way it is practiced in the agencies she had contact with. Susan had shown a remarkable amount of resolve to remove Peter from her life, she divorced him, she reported assaults, she identified herself to agencies as a victim of domestic abuse, she had pursued prosecutions, civil non-molestation orders, and had even had a panic alarm fitted in her home and entered refuges. She did all the things that victims of domestic abuse are advised to do.
- 12.2 In conclusion this review considers that Susan's death was predictable. There was consistent abuse, control, violence and stalking. Peter displayed nearly all of the commonly acknowledged high risk markers for committing homicide. The question of whether this homicide was preventable is more problematic.**
- 12.3 From a pragmatic viewpoint no agency received a call or had any information around the time of Susan's death alerting them to the fact that there was an immediate threat to her life. From this perspective it cannot be concluded that any agency could have prevented Susan's death on that night.**
- 12.4 From a wider perspective it is concluded that none of Susan's actions resulted in the abuse ending. Most of the action that Susan took, she did without a great deal of help. Susan lost faith in the police and other agencies to help her when nothing changed, and Peter was not dissuaded from abusing her. Reporting and following prosecutions, or stopping him from having contact with her, were both dangerous and difficult. She became resigned to managing Peter alone and this is what she says to the police officer in the recorded call about a year and a half before her death, and also to investigating officers in her fraud interviews a couple of months before she died. She said no matter what she did nothing worked, nothing stopped Peter or the abuse. The distress and defeat in her voice were clear.
- 12.5 Peter was controlling, abusive and violent. His behaviour was not addressed with any robust plan to encourage him to desist from his control of, and violence towards, Susan, or to punish him in a criminal justice context. He did not really have any reason to stop. Despite serious assaults he was able to continue with no sanction. It is interesting that when he was threatened with sanction he left the country, so clearly the thought of sanction alarmed him. When he was sentenced to life he became angry and aggressive in the court room and shouted at the judge. This suggests that the threat of sanction should be *real* and *constant* for abusers.
- 12.6 The conclusions, in consideration of these observations, will rest on three premises which will guide the recommendations:
- i) That the victim should be encouraged and able to seek help that is effective
 - ii) That the abuser should be challenged wherever possible with due consideration given to the ongoing safety of the victim
 - iii) That if there is a good understanding of the seriousness of domestic abuse, and a clear pathway for responding, staff would be more competent and confident in their responses

- 12.7 Susan lived a much compromised life, as a result of her poor health, and the abuse, stalking and control she received from Peter. For future victims of domestic abuse the conclusion of this review is that the three premises above, when applied to an agency's response may help victims feel more confident, help practitioners to respond with real help, and send a message to abusers that their behaviour won't be tolerated.
- 12.8 It is commented on a number of occasions by various agencies that Susan did not disclose, that she did not pursue prosecutions, and that she continued to have contact with Peter, as if she had free choice to choose to do otherwise. The failure to pursue prosecutions was because of fear, a very real and valid fear supported not only by Peter's behaviour, but by extant international research.
- 12.9 **Susan did not have the free choice to do as she pleased; this is the product of domestic abuse.** She was intimidated by Peter, and he controlled what she did. Consider that she variously reported to a number of people, beatings, strangulation, rape, threats to her life and that of her children and family and friends, assaults on her family in retribution for her actions, stalking, financial control, and homelessness. All these things were exacerbated by her failing health and terminal illness.
- 12.10 In conclusions we should also consider the effect of inaction after complaints on Peter too. He committed some serious offences against Susan, his children, and the wider family. He was not seriously sanctioned or challenged by anyone. There was no clear message that his behaviour was unacceptable. He had no reason to seek help with his behaviour, or to desist.
- 12.11 There are a number of learning points identified as arising from Susan's story. It is important to remember that learning must go further than the DHR panel. Learning must be achieved by all individuals who work in any particular agency.
- 12.12 Learning must also extend beyond gaining knowledge of particular legislation or agency procedure. Individuals must know *why* a certain procedure is in place so that it can be applied appropriately and effectively. Dissemination of the panel's learning then is of the most crucial importance.
- 12.13 The panel met to discuss dissemination of the recommendations and how learning could be cascaded. The Strategic Leadership group were included in this process and timetables for dissemination, and accountability were agreed.

13.0 Learning Points and Recommendations

- 13.1 The recommendations in this report will adhere to the SMART model in that they are Specific, Measurable, Achievable, Realistic and Timely.
- 13.2 In completing their IMRs certain agencies addressed issues that were raised by this review and those agencies have made recommendations for themselves which will be implemented and audited by the processes of this review. The recommendations from individual agency learning are noted below. The benefit fraud department recommendations are somewhat included in the housing recommendations. The recommendations from the Healthcare Trust are contained within the scope of the overall recommendations made by the DHR panel.
- 13.3 The individual recommendations from IMRs acknowledged by the review are:
- 13.4 Gloucestershire Constabulary: Since this homicide occurred Gloucestershire Constabulary have made a number of changes to their domestic abuse policy and procedures. They were inspected in November 2013 as part of an HMIC nationwide inspection into responses to domestic abuse. When they were re-inspected in June 2014 they were considered to have greatly improved. There is now strong leadership in place in the area of public protection, and as a result changes have been made to policy and practice. Extra training was given to frontline officers and staff, and a stronger multi-agency co-operation. Specifically:
- Within the MASH there are now daily triage meetings to discuss all the DA cases from the previous 24 hrs. These meetings are between the police, Children’s Social Care and GDASS. All aspects of risk are examined within the context of any current situation which allows fast-tracking of cases where appropriate. This is something both the Home Office and the Metropolitan Police are coming to see in practice as it is considered an innovative and practical solution.
 - The risk assessment tool (DASH) has been rolled into an intuitive process on a mobile platform; this is called VIST (Vulnerability Identification Screening Tool). It takes officers through key questions ensuring certain and important aspects are not missed, and that the voice of the victim is clearly heard. Future development will be around automated recording and risk analysis.
 - They have developed a risk based approach to offender management in that a number of risks are scored to identify the top 20 DA offenders in the county. The risks include for example, drugs/alcohol, mental health, children on a plan, repeat episodes, MARAC and so on. As a result this allows the Constabulary to investigate DA cases based on potential harm and ensure, if appropriate, an evidenced based approach to support reluctant or frightened victims.

In addition Gloucester Constabulary have made the following recommendations for themselves in their management review:

1.	The force to advocate and include in policy that a high risk marker/flag should be recorded against a High Risk offender who has come to the attention of police through a DA incident where strangulation is alleged.	Strangulation is recognised as a key indicator of High Risk. Where a perpetrator is identified as High Risk, an appropriate marker will be recorded against that individual’s nominal record – citing relevant high risk factors that relate to that person, e.g., strangulation, use of weapons etc. The ‘flag’ will remain attached to that individual. (CAADA recommend that the marker is removed after 12 months if no other incidents are reported)
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2.	Create a force system to enable quick and easy access to relevant safeguarding information and record of risks.	The current system is deemed sufficient to alert officers to the level of risk in respect of the victim. The creation of the new module will enable additional risk warnings and risk management plans to be linked directly to a victim and to be accessible.
3.	The force to ensure that the completion and quality assurance of DASH forms are an ongoing priority with results reported to Performance group for scrutiny.	Safeguarding is a force priority and domestic abuse forms part of this. The quality of and the compliance rate of DASH remains a key performance indicator which is scrutinised each month at the Performance Operations Meeting. The How-To Guide makes it very clear that officers and their supervisors have a responsibility to ensure clarity of information. <i>(The How-to guide is a comprehensive guide to force policy and procedure on domestic abuse)</i>
4.	The force to ensure that training continues within the Constabulary in respect of Domestic Abuse, Stalking and Harassment.	Link to HMIC recommendation 7 where updates will be recorded
5.	Create force system where the risk factors affecting vulnerability can be easily captured and recorded	A task & finish group has already been established to capture the risks posed to all vulnerable persons, with a view to ensuring that all risk management plans are located on one database and are accessible to all operational staff.
6.	The force to reinforce the Victim Code compliance	This is a force issue and is subject to regular bulletin entries
7.	The force to remind officers that the investigative process and the dialogue with CPS for allegations of strangulation is fundamental	It is not possible to establish a definitive guidance document in relation to the classification of offences where strangulation has occurred. The evidence that may exist is very much dependent on a case-by-case basis and dialogue / consultation with CPS is necessary in all cases prior to charge.

13.5 Cheltenham Borough Homes:

- a) A Domestic Abuse Forum will be set up with a lead manager from CBH to chair the Forum and drive improvements.
- b) The Forum will produce policies and procedures that will be ratified at their Management and Board.
- c) The Forum will meet regularly but as a minimum every other month.
- d) The Forum will identify and ensure delivery of training, both at an enhanced level and an awareness level that will be rolled out to all CBH staff.
- e) The Forum will produce and monitor DA statistics.
- f) The Forum will link to MAPPA, MARAC, GDASS and any other best practice organisations.
- g) The Forum will deliver an Action Plan that will encompass the Learning Points above and any other defined work that is required.
- h) The Forum will review its work on an annual basis.
- i) The Forum will incorporate these ideals into their Terms of Reference.

13.6 In addition there are the specific recommendations of the review panel which fall into two categories; focused and general. This is because the process of the review highlighted that there was some fragmentation in the approach to domestic abuse across agencies, and it was felt that a set of recommendations which could be considered as generally relevant to all organisations would create a more consistent and shared approach that would benefit the people of Cheltenham and Gloucestershire. However, there are some recommendations which are focused on particular organisations.

13.7 The panel also concluded that good policy will better succeed if the basic knowledge for the *reasons* for that policy are disseminated along with the policy itself.

General learning points and recommendations:

Learning Point 1: The review found that there is no consistency across Gloucestershire in its approach to domestic abuse. Some organisations did not have a policy at all. The panel felt that this was something that should be addressed so that employees were knowledgeable and confident in their approach to domestic abuse, and that victims would experience consistency to build trust. In addition, the panel found that the way information was shared between agencies created fragmentation in the knowledge of Susan's circumstances. Had more been shared and known Susan may have received better support. This was made clear when she applied for housing for example.

Recommendation 1

Each public-sector agency that is represented on the DHR panel and on Cheltenham Strategic Leadership Group (SLG), will adopt a domestic abuse policy and procedures, based on a county-wide template, to guide how their agencies responds to domestic abuse and stalking. VCS agencies will also be encouraged to adopt a domestic abuse policy.

This will guide how their agency responds to domestic abuse and stalking. VCS agencies will be encouraged to adopt a domestic abuse policy. As part of the development of the policy, it is suggested that there be encouragement for victims to consistently disclose their domestic abuse to all agencies they come into contact with. Domestic abuse is a *course of conduct* problem, and needs to be dealt with considering this. In a course of conduct offence a log should be kept of all 'incidents' or behaviours. Domestic abuse victims are currently only encouraged to keep a log in incidents of stalking.

This panel also recognise that it may be dangerous for a victim to keep any log with themselves. In consideration of this the panel felt that victims could be encouraged to make an information trail for their own benefit, by disclosing to agencies who would then make a record, so that in the future there is evidence of their domestic abuse. When a disclosure of abuse is made for a specific purpose like a housing application for example, the agency will often seek corroboration or evidence of the assertion. The panel cross referenced this recommendation to recommendation 3, which is to use staff training to encourage disclosure.

It is also observed that encouraging victims to disclose safely, does not remove any responsibility on agencies to share information when safe and appropriate. The panel also note that this recommendation could be seen to be placing responsibility on the shoulders of victims, we recognise this critique, but feel that whilst information sharing is so fraught with problems, that it may be safer to take account of those difficulties and help victims create a trail in partnership with agencies.

To ensure that there is consistency in the way the policies operate, and the fact that the majority of these agencies operate on a county-wide basis, it is suggested that the Gloucestershire Domestic Abuse and Sexual Violence Commissioning Group defines the core elements of the county-wide template that each agency can adapt to include their own procedures detailing their approach and response to disclosures of domestic abuse by service users or their employees. The policy template will be produced by December 2017. It will be the responsibility of each agency to add their procedure guidance to the document by June 2017.

Learning Point 2: with reference to LP1, the panel felt that if consistency of approach to domestic abuse would benefit victims and employees, then that consistency should stretch to those agencies and businesses that are contracted to provide public-facing services.

Recommendation 2

There will be a requirement that selected agencies delivering public-facing services on behalf of public sector partners have a domestic abuse policy.

The Strategic County Domestic Abuse and Sexual Violence Coordinator will explore the possibility of how procuring and tendering services could include an obligation on providers to illustrate that they have a domestic abuse policy in place. The county will forge links with other areas that are progressing similar work, including Brighton and Hove Council. This recommendation will be followed up by the Cheltenham Strategic Leadership Group.

Learning Point 3: The panel observed that victims of domestic abuse should know that Gloucestershire agencies and their partners take domestic abuse seriously. In this case it seemed that Susan had lost faith in the agencies who were supposed to help. There is therefore a need to train staff across agencies to create a consistent message for victims

Recommendation 3

A training needs analysis will be coordinated by the GDASVIG and a plan developed for how to roll out training across agencies.

The panel feels that there is a need to train staff across agencies to create a consistent message for victims. It is important that all frontline professionals recognise that domestic abuse and stalking are dangerous, and they should always take disclosure seriously. Ongoing training needs to be integrated into the domestic abuse policy. Awareness that domestic abuse can be dangerous and should be taken seriously should be part of *all* staff training, including senior managers. This should include GPs and community nurses.

The Domestic Abuse and Sexual Violence Commissioning Group will absorb this recommendation into the second strategic objective of the strategy whereby a training needs analysis across the partnership will be explored to implement these changes.

This needs analysis will be coordinated by the DASVCG

Learning Point 4: The review highlighted that public awareness of domestic abuse and how and where to find support did not appear to be high. Susan's family and friends were often abused by Peter, but local services were not used

Recommendation 4

An awareness campaign implemented using the branding of the local domestic abuse specialist agency and the *glostakeastand* website to raise awareness.

The GDASS 'daisy' should be a visible reminder of the help available as well as the *glostakeastand* website and branding. This awareness campaign could coincide with implementation of the countywide domestic abuse policy. This particular recommendation will be coordinated by the Strategic County Domestic Abuse and Sexual Violence Coordinator and the DASVCG.

Recommendations 1 to 4 together create a model for a consistent approach to domestic abuse in Gloucestershire, that is: a shared domestic abuse policy; a requirement that any agency dealing with public sector partners should have a domestic abuse policy; that a comprehensive training needs analysis is completed, and training delivered across all agencies and staff; use of county agencies and branding to indicate the shared policy and encourage and remind victims to disclose; an awareness campaign supported by local media to let everyone know about the GDASS daisy and the *glostakeastand* website.

Learning Point 5: A trial is a public event, and the transcript and narratives should reflect reality. The chair observed on attending the trial that the prosecution's opening statement reflected some damaging beliefs. The panel considered that *all* agencies should be aware of the way domestic abuse is practised, and especially those who have a public voice which stays on record, and may influence wider beliefs.

Recommendation 5

As a trial is a public event and is retained in public records it should reflect reality, it is recommended that CPS prosecutors in domestic homicide cases and Magistrates have training in recognising the practices of coercive control, stalking and domestic abuse.

A better understanding of domestic abuse could then have a place in the forensic narrative and form part of the official understanding of what happened in individual cases where domestic abuse is relevant. Invitations to train with other agencies will be given to local CPS prosecutors and CPS direct call handlers. The CPS acknowledged a need for better understanding in their staff and welcomed the invitations. It is hoped the invitations will be accepted.

Learning Point 6: The panel recognised that Susan was a vulnerable person in common thinking, in that she was physically frail, suffering a terminal illness, receiving constant community support for her health, and often homeless. However, she was not considered vulnerable in different organisational definitions. The panel considered however, that she was intimidated, both in common thinking, and in official definitions of intimidation.

Recommendation 6

It is a responsibility of the police to identify vulnerable and intimidated witnesses and respond accordingly.

The official guidance, which now places a responsibility on police officers to identify intimidated witnesses and victims set out in the *Code of Practice for Victims of Crime* (Office for Criminal Justice Reform 2005), should be common knowledge and in common practice. Most, if not all, domestic abuse victims are intimidated even if they do not fall fully within the definition. It may be good practice in cases of domestic abuse, especially where a victim or witness retracts a statement, or is known to have done this before, that police consistently make use of the approach set out in the official guidance. There is a copy of this guidance published on the Gloucestershire Constabulary website. We do not suggest that Gloucestershire Police do not observe this responsibility but wish to underline the importance of it in this report for the police, and partner agencies like the CPS.

Learning Point 7: It was found that the help Susan received from health services appeared to focus solely on her physical problems. At least one agency which had care of Susan had no domestic abuse policy, and all health agencies which supplied information to this panel did not make good notes about the abuse Susan was suffering, or its impact on her health and wellbeing. This could be because of poor practice in recording, or because Susan did not disclose. Either way there is learning that domestic abuse is relevant to health and wellbeing, and that Susan should have been encouraged to talk about this aspect of her life with carers, especially with her GP. Susan disclosed anxiety and depression in the year before her death, specifically related to the fraud investigation and financial abuse, yet there is nothing in her notes to suggest domestic abuse.

Recommendation 7:

All health practitioners and professionals should consider Routine Enquiry in cases where depression or anxiety, or any condition potentially related to domestic abuse, is discussed with a patient.

It was found that Susan did not disclose domestic abuse to GPs or community nurses, despite disclosing to other agencies. Routine Enquiry is used widely in a health setting and research has shown that victims respond well to it in a health environment. This is also related to achieving recommendations 1, 3 and 4. It is recommended that in implementing the county domestic abuse policy, GP practices consider Routine Enquiry as standard in cases of anxiety, depression and traumatic injury, or other complaints and problems which could be linked to domestic abuse. This recommendation should fall into the training needs analysis from recommendation 3. There is also a software and training package specifically for GPs known as IRIS which supports GPs through a decision making process in cases of domestic abuse.

Learning Point 8: Financial abuse is more probable, than merely possible, in cases of domestic abuse where there is coercion and control. The panel felt that training for fraud investigators especially, in financial abuse would benefit victims.

Recommendation 8

Benefit Fraud investigators should be aware that in cases where coercive control is exercised that financial abuse and control of the victim's finances is more probable than possible and should therefore be trained in domestic abuse and have enhanced training in financial abuse.

Any accusations by the victim of domestic abuse and control of their finances by an abusive partner should be taken seriously and considered as relevant to the investigation. It is recommended that fraud investigators employed by Cheltenham Borough Council have training in recognising domestic abuse, coercion and control, and in particular financial abuse. This is also covered in the countywide strategy for training needs analysis in recommendation 3.

Learning Point 9: It is possible that had Susan been assessed as a high risk victim of domestic abuse using the DASH Risk Identification Checklist (which has been adopted by Gloucestershire Police), she may have received crucial help and a safety plan. Susan was high risk and could have benefited from being referred to MARAC.

Recommendation 9

This is a two-point recommendation

All agencies should have identified individuals who are competent in identifying risk factors and understanding their significance (eg strangulation)

More agencies need to be trained including:

- **Social care**
- **Housing**
- **Probation**
- **Local councils**
- **Benefits Agencies**
- **Health Agencies**

Learning Point 10: In this case it was found that the behaviour of the perpetrator was not robustly addressed by the police. It was considered that recognising the high risk an abuser poses should be partnered with focus on the abuser. This recommendation also considers comments made by the CPS about the need for good evidence gathering.

Recommendation 10

Police should use their professional judgement and consider all options available to them when attending calls for help in cases of domestic abuse.

The police have a number of actions available to them, all of which would be aided by meticulous evidence gathering at the time. The use of evidence gathering aides, such as body worn cameras should be discussed at the next available Public Protection Service Delivery Board. Specific guidance on new legislation which focuses on course of conduct offending and evidence gathering should also be discussed.

Learning Point 11: The Domestic Abuse Courts are no longer staffed by specially trained individuals and this could be having an effect on the victim's faith in the system. This may become crucial in effectively prosecuting the new coercion and control offences in the Serious Crimes Act 2015.

Recommendation 11

The specialist domestic abuse court should be staffed by professionals with enhanced training in domestic abuse and coercive control. This would include the prosecutors, magistrates, judges and supporting personnel.

Learning Point 12: There was no support offered to the children in this case, in fact their potential suffering was missed by health and law enforcement agencies.

Recommendation 12

There should be an assessment of the needs of children and young people where Domestic Abuse has occurred and this should be part of any risk assessment. It is considered that there is a need for specialist group and individual programmes which would support children witnessing or affected by domestic abuse. This review recommends that local agencies are supported in bidding for funding to begin developing such support for children.

It is considered that there is a need for specialist group and individual programmes which would support children witnessing, or affected by, domestic abuse. This review recommends that local agencies are supported in bidding for funding to begin developing such support for children. Specifically this recommendation could be explored by GDASS and Infobuzz with the support of the OPCC and the DASVCG. Infobuzz have staff trained to deliver specific domestic abuse programmes to children, and have those programmes ready to deliver. This would only take some funding to start. It may also be timely to consider nurturing circles or inclusion of domestic abuse in the school PSHE curriculum. It appears that schools develop and design their own PSHE curriculum, so encouragement to provide more support to children by schools should be given.

Cheltenham Strategic Leadership Group requires that all recommendations contained in agency IMRs be fully implemented and that agencies evidence that action has been taken to implement all recommendations to the panel. This should be done before the publication of this report. It is recognised that some recommendations will take time to complete, but the action plan should be in process before the panel disbands, and will be subject to future scrutiny by the Strategic Leadership Group.

Appendix 1

Learning Point	Recommendation	Timescale
1. There is no consistency across the county in responding to domestic abuse	Each public-sector agency that is represented on the DHR panel and on Cheltenham Strategic Leadership Group (SLG), will adopt a domestic abuse policy and procedures, based on a county-wide template, to guide how their agencies responds to domestic abuse and stalking. VCS agencies will be encouraged to adopt a domestic abuse policy.	Adoption of Concordat by agencies by March 2017
2. Consistency should stretch to provider agencies contracted to deliver public-facing services	There will be a requirement that selected agencies delivering public-facing services on behalf of public sector partners have a domestic abuse policy	Adoption of standard clauses by March 2017
3. There is a need to train staff across agencies to create a consistent message for victims	A training needs analysis will be coordinated by the GDASVIG and a plan developed for how to roll out training across agencies	March 2017
4. Local people were not aware of the help available to them	An awareness campaign implemented using the branding of the local domestic abuse specialist agency and the glostakeastand website to raise awareness.	November 2016
5. There is not a sufficiently wide understanding of how domestic abuse is practised and as such damaging beliefs can be reflected and left unchallenged in the criminal justice process.	As a trial is a public event and is retained in public records it should reflect reality, it is recommended that CPS prosecutors in domestic homicide cases and Magistrates have training in recognising the practices of coercive control, stalking and domestic abuse	With immediate effect
6. Vulnerable and intimidated witnesses were not always identified or special measures applied for by the CPS in court proceedings	It is a responsibility of the police to identify vulnerable and intimidated witnesses and respond accordingly	Ongoing
7. Those responsible for Susan's health and wellbeing did not follow up signs of domestic abuse	All health practitioners and professionals should consider Routine Enquiry in cases where depression or anxiety, or any condition potentially related to domestic abuse, is discussed with a patient	March 2017

8. Benefit Fraud investigators did not consider financial abuse or control	Benefit Fraud investigators should be aware that in cases where coercive control is exercised that financial abuse and control of the victim's finances is more probable than possible and should therefore be trained in domestic abuse and have enhanced training in financial abuse.	March 2017
9. An effective risk assessment was not performed	<p>All agencies should have identified individuals who are competent in identifying risk factors and understanding their significance (eg strangulation)</p> <p>More agencies need to be trained including:</p> <ul style="list-style-type: none"> • Social care • Housing • Probation • Local councils • Benefits Agencies • Health Agencies 	June 2017
10. Perpetrator behaviour is not robustly challenged	Police should use their professional judgement and consider all options available to them when attending calls for help in cases of domestic abuse. The police have a number of actions available to them, all of which would be aided by meticulous evidence gathering at the time. The use of evidence gathering aides, such as body worn cameras should be discussed within the Constabulary	Ongoing
11. The domestic abuse court in Cheltenham is not staffed by trained individuals any more	The specialist domestic abuse court should be staffed by professionals with enhanced training in domestic abuse and coercive control. This would include the prosecutors, magistrates, judges and supporting personnel.	June 2017
12. There is a lack of specialist support for children affected by domestic abuse	There should be an assessment of the needs of children and young people where Domestic Abuse has occurred and this should be part of any risk assessment. It is considered that there is a need for specialist group and individual programmes which would support children witnessing or affected by domestic abuse. This review recommends that local agencies are supported in bidding for funding to begin developing such support for children.	June 2017
13. Strangulation - Early Recommendation	All local agencies recognise the significance of strangulation or choking attempts when they happen in the context of domestic abuse. Research was considered which showed a correlation between such assaults and future homicide	Complete