South Staffordshire Council

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

in respect of

L – December 2016

Chris Few

June 2019

South Staffordshire Council

CONTENTS

INTRODUCTION

1 Summary of Circumstances Leading to the Review

1.1 The victim (L) and perpetrator (M) met around June 2016 and towards the end of October 2016 they moved in together at a rented property in South Staffordshire. From evidence given at the trial of M the Court concluded that apart from "the stresses and strains that happen in nearly all relationships" L and M were happy and planning a future together.

1.2 In December 2016 the emergency services were called to their address by M, who stated that he had found M deceased on the floor at the foot of the stairs. M had a number of injuries and M was arrested. M informed the Police that on the evening before her death he and L had consumed alcohol and cocaine and engaged in consensual rough sexual activity. After leaving L for a short time he found her at the foot of the stairs, bleeding from a head wound. He said L was incapable of getting back up the stairs and that he was unable to carry her. He left her at the foot of the stairs and went to bed, finding her deceased when he woke the following morning. An initial post mortem examination of L was inconclusive and M was released from custody after interview.

1.3 The final pathology report in relation to L identified her cause of death as a combination of multiple blunt force trauma and alcohol intoxication. In November 2017 M was re-arrested and charged with murder and causing grievous bodily harm with intent. M maintained that some of the injuries sustained by L were caused by consensual sexual activity but offered no explanation for head and eye injuries.

1.4 In December 2018 M pleaded guilty to manslaughter through gross negligence and was subsequently sentenced to 3 years and 8 months imprisonment. M's guilty plea related to him leaving L unsupervised and failing to contact the emergency services in circumstances where "a risk of death as a result of her condition would have been obvious."

1.5 A DHR Scoping Panel met on 8 February 2017 to consider the circumstances. On the information available at that time the Panel was unable to reach a conclusion on whether the criteria for commissioning a Domestic Homicide Review had been met. Consequent to receipt of the final pathology report, the CSP Chair agreed to commission a Domestic Homicide Review on 20 December 2017.

2 Review Process

2.1 The Review considered in detail the period from March 2016, to ensure that the whole of the relationship between L and M was considered, until the date of L's death in December 2016.

2.2 In the context of the areas for consideration outlined at Section 4 of the Statutory Guidance the Review specifically considered whether domestic abuse was occurring in the relationship of L and M, and if so, why this was not known to any agency.

2.3 Management Review Reports and Summary Information Reports were submitted by:

- Staffordshire Police
- West Mercia Police
- West Midlands Ambulance Service NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- Worcestershire Clinical Commissioning Groups (in respect of primary health care services)
- Worcestershire County Council Children's Social Care

- Wyre Forest District Council

2.4 The Review Panel was chaired and the Review was written by Chris Few, an Independent Consultant. Mr Few has had a career in law enforcement and undertaken responsibility in senior leadership roles. He has completed the Home Office online DHR learning provision in 2013, attended a Home Office sponsored AAFDA/STADV facilitated training workshop for DHR chairs in 2017. Since 2008 he has worked as an Independent Consultant in Somerset, Bristol, Gloucestershire, Oxfordshire, Bedfordshire, Northamptonshire, Nottinghamshire, Nottingham City, Derbyshire, South Yorkshire, Stoke on Trent and Staffordshire.
Since that time, he has chaired Review Panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide and Serious Case Reviews as outlined. He has no current or historic personal or professional connection with any of the agencies and professionals involved in the events considered by this Review.

2.5 The Review Panel comprised the following agency representatives:

- Mark Harrison
  Investigator – Policy Review and Development Team
  Staffordshire Police

- Victoria Downing
  Senior Investigating Officer
  Staffordshire Police

- Helen Marshall
  Community Safety Officer
  South Staffordshire District Council

- Julie Long
  Principal Community Safety Officer
  Staffordshire County Council

- Sue Coleman
  Chief Executive
  West Mercia Women's Aid

- Ellen Footman
  Designated Nurse for Safeguarding Children and Adults
  Worcestershire Clinical Commissioning Groups

- Deborah Narburgh
  Head of Safeguarding
  Worcestershire Acute Hospitals NHS Trust.

3 Scope of the DHR (Terms of Reference summary)

3.1 The Review should consider in detail the period from March 2016, to ensure that the whole of the relationship between L and M was considered, until the date of L's death in December 2016.

3.2 Agencies have knowledge of L and M from incidents prior to March 2016 and the Review will gather and consider summary information regarding these.

3.3 The focus of the DHR will be maintained on the following subjects:

Name	L	M
Relationship	Victim	Perpetrator
Gender	Female	Male
Age (December 2016)	26 years	38 years
Ethnicity	White North European	White British

3.4 A review of agency files should be completed (both paper and electronic records); and a detailed chronology of events that fall within the scope of the Domestic Homicide Review should be produced.

3.5 An Overview Report will be prepared in accordance with the Guidance.

3.6 The key issue to be addressed within this Domestic Homicide Review is whether domestic abuse was occurring in the relationship of L and Y, and if so why this was not reported to any agency. This should be considered in the context of the general areas for consideration listed at section 4 of the Guidance.

3.7 Reference was also made to the Sentencing Remarks of Mr Justice Knowles in relation to Y[1].

3.8 In addition to the Scoping Panel Meeting in February 2017 the Review Panel met on two occasions, in April 2018 and February 2019 to consider contributions to the Review and emerging findings.

3.9 This Overview Report was endorsed by the Review Panel on 12 June 2019 and forwarded to the Chair of the South Staffordshire Community Safety Partnership. On 9 September 2019 the report was presented to and endorsed by the South Staffordshire Community Safety Partnership.

4. Summary Chronology

4.1 L met M around June 2016 consequent to M and L's father being acquainted through them frequenting the same public house and having a shared interest in horse racing.

4.2.1 L subsequently told her family that she was employed by M as his Personal Assistant and had been provided with a car. It was however evident to them by July / August 2016 that there was a personal relationship between L and M. This was confirmed by L who told her father that

[1] https://www.judiciary.uk/wp-content/uploads/2018/12/

they had been staying at a local hotel, joking that they had used her father's surname to book in as a married couple.

4.2.2 L's sister stated that L was really happy with M and he seemed smitten with L. She stated that she had never known L to be so happy and content with life.

4.2.3 From evidence given at the trial of M the Court concluded that apart from "the stresses and strains that happen in nearly all relationships" L and M were happy and planning a future together.

4.2.4 Early in the relationship L told her sister that M enjoyed "rough sex" which would include using a belt to smack her. L showed her injuries resulting from this. L's sister was not surprised by this as she was aware that L had engaged in "kinky" sex with previous partners, although she was not aware of L sustaining bruises during sex in any earlier relationship.

4.2.5 In July 2016 L saw the healthcare professional at her GP surgery. She described crying, feeling tingling in her hands and feet, not sleeping well and feeling worried about herself and her child (then aged 8). She was prescribed a 7-day course of medication (DiaLepam) and advised to see her GP if her symptoms persisted.

4.2.6 In mid-December 2016 L and M were intending to take a holiday in the Middle East. L and her child (then aged 8) were booked to fly out one day, with M and his child (then aged 9) following the next day. Before the planned holiday L said to her father that she was "ever so scared". Her father thought that she was referring to her first long haul flight, travelling alone to the Middle East, and did not query what L meant by the remark.

4.2.7 On the morning of the day before L was due to fly out on holiday in December 2016 the emergency services were called by M to the address shared by him with L. He stated that he had found L, not breathing, on the floor at the foot of the stairs.

4.2.8 After a night out and rough sexual activity M said, that after leaving L for a short time he found her at the foot of the stairs, bleeding from a head wound and clutching the bannister. He said L was incapable of getting back up the stairs and that he was unable to carry her. He left her at the foot of the stairs and went to bed, finding her deceased when he woke the following morning.

4.2.9 M's plea of guilty to manslaughter by gross negligence related to him leaving L unsupervised and failing to contact the emergency services in circumstances where "a risk of death as a result of her condition would have been obvious." M was subsequently sentenced to 3 years and 8 months imprisonment.

5 Family Engagement

5.1 Family members of L were advised that the Review was taking place at its outset. Contact with family members was established through the Police Family Liaison Officer who hand delivered and explained letters from the Review Panel Chair along with Home Office leaflets describing the review process and available support services.

5.2 Following conclusion of the criminal prosecution the mother and father of L met with the Review Panel Chair on 6 February 2019. L's sister also contributed to the Review, releasing to the Panel six witness statements which she had earlier made to the Police. The contributions of family members to the Review are incorporated into this report.[2]

[2] Family members were asked if they wished a pseudonym to be used for L in this report. They stated that they did not and initials, having no relationship to those of individuals, have therefore been used to anonymise the report.

5.3 M was advised in writing, via his Solicitor, that the Review was taking place and provided with an explanation of the review process. He did not wish to contribute.

5.4 Members of L's family were given sight of this report on completion and prior to its submission to the Home Office. An amendment to the report requested by L's father was incorporated in the submitted report.

FINDINGS AND CONCLUSION

5.5 The Government definition of domestic abuse, adopted in Staffordshire, is:

> Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:
> - Coercive control
> - Psychological and/or emotional abuse
> - Physical abuse
> - Sexual abuse
> - Financial abuse
> - Harassment
> - Stalking
> - Online or digital abuse.

5.6 The judgement of the Mr Justice Knowles when sentencing M, supported by legal precedent, was that an individual cannot in law consent to being assaulted to cause at least actual bodily harm and that accordingly, notwithstanding the consensual nature of the sexual activities between M and L in the period just prior to her death, M had acted unlawfully in causing L actual bodily harm[3]. It follows that L was by definition a victim of domestic abuse at the hands of M, at least during the period just prior to her death. Bruises to L which were observed earlier by her sister and the lesion observed by the healthcare professional at L's GP surgery (see 4.8), if this was a human bite mark, would also be the result of domestic abuse.

5.7 The Review Panel considered that there should be greater professional awareness of legal precedent around consensual sexual activity and the implications of this in the context of responding to domestic abuse and make a recommendation for the promotion of this.

5.8 There is no evidence that L regarded herself as a victim of abuse and all indications are that she did not. Other than injuries sustained during sexual activity there are no indications that domestic abuse was a facet of their relationship.

5.9 In the context of a relationship which was by all accounts happy it is therefore unsurprising that L did not seek assistance from the domestic abuse services available in Staffordshire[4] or of the professionals with whom she came into contact during her relationship with M.

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[3] Mr Justice Knowles also cited precedent in his judgment regarding the vaginal injury to which the grievous bodily harm charge against Y had related and in respect of which the prosecution offered no evidence, that; "A woman may lawfully consent to having something inserted into her vagina (or rectum) for the purposes of sexual gratification but without an intention to cause injury, even if doing so carries a risk of injury, and injury is indeed caused."

[4] Since 1 October 2018, a new holistic domestic abuse service has been operating across Staffordshire and Stoke-on-Trent, jointly commissioned by the Staffordshire Commissioner's Office, Staffordshire County Council and Stoke-on-Trent City

5.10 A healthcare professional at L's GP surgery saw her on three occasions during the period examined by this Review. In September 2016 L visited the Practice with a lesion to her leg which she attributed to a spider bite. The healthcare professional recorded that the wound looked like a human bite mark but did not raise this with L as she thought the bite was related to sexual activity and she felt it was not her business to ask.

5.11 It was documented by the healthcare professional that L reported being happy in her four-month-old relationship but there was no specific discussion of whether domestic abuse was present in the relationship.

5.12 Department of Health Policy is that routine enquiry, asking all patients about their experience of domestic abuse regardless of any visible signs of abuse, should take place in maternity and adult mental health settings. In other settings Department of Health Guidance[5] is that domestic abuse should be explored "…if things are not adding up…" The Review Panel considered that there was a lesson to be learned and a missed opportunity to explore the potential for domestic abuse in this case, albeit it is highly unlikely that this would have led to identification of L as a victim of domestic abuse.

5.13 The Review Panel identified that the village where L and M were living together, their previous addresses and the GP surgeries at which both were registered are all in a small area of rural South Staffordshire / Worcestershire. They considered the impact on the identification of Domestic Abuse and responses by practitioners living and working in rural communities with those to whom they are providing services, particularly where relationships are longstanding.

5.14 The Review Panel considered that the familiarity between L and the healthcare professional at her GP's surgery over a period of 20 years may have blurred professional boundaries and led the healthcare professional to feel she did not need to explore the potential for domestic abuse when she saw L with what appeared to be a human bite mark in September 2016.

5.15 Conversely the Review Panel also identified that disclosure of Domestic Abuse is more likely where a victim feels safe and able to talk openly. Whilst this may be achieved through sensitive proactive enquiry by properly trained professionals[6], a longstanding relationship may also contribute to the required trust in the professional.

5.16 The Review Panel concluded that alongside professional training on identification and responses to domestic abuse, professionals living and working in small and rural communities should have regard to the potential for this to impact on their practice. In this regard the Review Panel were advised of a recent Case Review in Worcestershire which had addressed this issue and recommended that "Practitioners should be aware of the influence and pressure that can be exerted when professionals and subjects reside in close proximity and particularly within small communities." L's GP practice is in Worcestershire and is subject to the implementation plan for that recommendation. The Review Panel did however consider that this issue is equally applicable across South Staffordshire and adopted this as a recommendation of this Review.

Council. Services for victims are provided by Victim Support and support for perpetrators is provided by the Reducing Re-offending Partnership; both are based in Staffordshire and operate under the name of "New Era".

[5]Responding to domestic abuse - A resource for health professionals
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

[6] Over the last 5 years Worcestershire CCGs provide a rolling programme of training to GP Practices which includes Domestic Abuse. L's GP Practice has an up to date Domestic Abuse Policy.

5.17 The Review Panel considered whether a disparity in the age and wealth of L and M may reflect or have led to a relationship in which L was subject to coercion.

5.18 The Review Panel noted that L was dependent upon M through him providing her with a home and a desirable lifestyle. West Mercia Police informed the Review Panel that the ability to provide such a lifestyle and the reluctance of partners to give it up were believed to have been exploited by M in previous relationships. It was suggested that this may have been the case in M's relationship with L.

5.19 The review panel also considered whether L's situation (particularly in July 2016) may have made her more vulnerable.

5.20 It is clear that the relationship led to L having a materially more desirable and secure lifestyle It is equally clear that L was happy in the relationship. The Review Panel took the view that the distinction between a relationship in which a more affluent partner shares their lifestyle with the other and one in which this could be seen as coercive is likely to be a fine and subjective one. In this case the Review found no indication that L saw herself as coerced by M or that this was the intent of M.

RECOMMENDATIONS

5.21 The Review Panel made the following two recommendations:

5.22 ***That the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should promote professional awareness of the influence and pressure that can be exerted when professionals and subjects reside in close proximity and particularly within small communities through domestic abuse training provision and in connection with publication of this Review.***

5.23 ***That the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should promote professional awareness of legal precedent around consensual sexual activity and the implications of this in the context of responding to domestic abuse.***

5.24 Recommendations for action to improve services were also made by Worcestershire Clinical Commissioning Groups that:

L's GP Practice, in line with provision at all GP practices, should:

- ***Ensure that all GPs and other clinical staff at the practice have completed Domestic Abuse training which includes recognition of the indicators of Domestic Abuse (by 31.5.2019) and provide on-going training for staff to ensure they continue to meet their roles and responsibilities in line with current guidance.***

- ***Raise awareness with all GPs and other clinical staff at the practice of the local Multi-agency Domestic Abuse Pathway; and of policies and processes in relation to domestic violence and abuse, which includes the pathway for victims, perpetrators and children including referral to MARAC/SARC/Women's Aid etc (by 31.5.2018).***

- ***Raise awareness with all GPs and other staff at the practice of the Practice's Domestic Abuse Policy (by 31.5.2018).***