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Western Suffolk Community Safety Partnership

Domestic Homicide Overview Report Executive Summary regarding the death of Carol, who was killed in January 2020

Written by:

Steve Appleton,
Previously Managing Director
Contact Consulting (Oxford) Ltd

Independent Chair and Author
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A message of condolence

The Domestic Homicide Review Panel wishes to express its condolences to the family and friends affected by the events described in this report. The panel hopes that the process will provide some answers to their questions.

Introduction

This Domestic Homicide Review (DHR) Overview Report examines agency responses and support given to Carol, a resident of West Suffolk, prior to her death in January 2020.

Carol's death was notified to Western Suffolk Community Safety Partnership (WSCSP) on 20 January 2020. She died as a result of 10 stab wounds and compression of her neck. The perpetrator, her ex-partner Colin, was arrested and charged with Carol's murder.

Carol was a white British woman living in Suffolk. She had had a number of relationships with male partners over the past two decades. Many of these relationships had been characterised by domestic abuse perpetrated against her.

The perpetrator, Colin, had been in a relationship with Carol for a relatively short period of time. Colin originates from Essex and there are relevant criminal convictions relating to domestic abuse apparent on his criminal record.

Carol and Colin were both living in Suffolk, although are understood to have been residing separately at the time of Carol's death.

Police had been in contact with Carol in the days immediately preceding her murder. She had contacted them to say that she had broken up with Colin and that he had not taken this news well. He had continued to try to make contact with her by phone and had stated that if she stopped seeing him she would regret it.

In the late evening of the day of her death, one of Carol's relatives called the police to report that a man was threatening her with a knife. The police contacted the ambulance service and having arrived on scene, called for a second ambulance. It has been stated that Carol had been stabbed ten times and had also suffered a compression of the neck.

Ambulance crews administered basic life support but Carol was declared deceased at the scene. Colin was arrested and subsequently charged with murder and remanded in custody to await trial. The trial concluded in June 2021, when Colin was convicted of murder.

The DHR process

This DHR was commissioned because it meets the definition detailed in paragraph 12 of the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2016). The review has followed the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.

The police made the referral to the Western Suffolk Community Safety Partnership (WSCSP). The WSCSP commissioned the DHR in January 2020. The independent chair and author was appointed in May 2020. The impact of COVID-19 on local authority operations meant there was some delay in the appointment of a Chair and author for this DHR.

At the time of the DHR there was one other parallel review in progress. This was a review being conducted by the Independent Office for Police Conduct (IOPC). It was instigated following a complaint from Carol's family in respect of contact by both Suffolk and Cambridgeshire police in the weeks prior to her death. The IOPC investigation was suspended in September 2020 pending the outcome of the trial of the perpetrator.

A pre-inquest hearing took place in mid-June 2021. The Suffolk Coroner has determined that an inquest will be held. This has been listed for May 2022.

A first panel meeting was held in May 2020, following a period of scoping and then Individual Management Review (IMR) completion and submission. The process was concluded in September 2021. The DHR panel met virtually four times, as well as additional discussions by teleconference. The Chair also held discussions by phone with the DHR lead within the CSP.

The Domestic Homicide Review has been conducted in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004. It has since been updated and was republished in December 2016.

Contributors to the Domestic Homicide Review

Individual Management Reports (IMRs) were requested from the agencies that had been in contact with or providing services to Carol. The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of contact and service provision by agencies with both the subjects of the DHR.

The IMRs were to review and evaluate this thoroughly, and if necessary, to identify any improvements for future practice. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

Ten agencies contributed to the review through the submission of Individual Management Reviews and the provision of initial scoping information. Those agencies were:

- Suffolk Police
- Cambridgeshire Police
- Cambridgeshire Independent Domestic Violence Advisor Service
- Cambridgeshire & Peterborough Clinical Commissioning Group
- Cambridgeshire & Peterborough NHS Foundation Trust
- Cambridgeshire Children's Services
- East of England Ambulance Service NHS Trust
- Cambridgeshire County Council
- Cambridgeshire & Peterborough Domestic Abuse and Sexual Violence Partnership
- Ipswich, East Suffolk and West Suffolk Clinical Commissioning Group

The agencies identified above each provided IMRs that were reviewed by the panel and used by the panel in reaching their conclusions.

Other contributors to the DHR

As part of the DHR, the Chair was able to speak with Carol's father, along with his advocate from Action After Fatal Domestic Abuse (AAFDA).

The Domestic Homicide Review Panel Members

Steve Appleton	Independent Chair and author
Cllr Joanna Spicer	Western Suffolk CSP Chair
DCI Barry Byford	Suffolk Police
Linda Coultrup	Cambridgeshire & Peterborough Clinical Commissioning Group (CCG)
Christine Hodby	Ipswich, East Suffolk and West Suffolk Clinical Commissioning Group (CCG)
Mercedes Macfarlane	East of England Ambulance Service Trust NHS
Julie May	Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) (Children)
Julia Cullum	Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership
DCI Andrea Warren	Cambridgeshire Police
SIO Pushpa Guild	Cambridgeshire Police
Jim Bambridge	Cambridgeshire Police
Darren Butler	Cambridgeshire and Peterborough NHS Foundation Trust
Aidan O'Reilly	Cambridgeshire County Council Social Care (Children)
Melanie Yolland	Suffolk County Council, Domestic Homicide Review Lead

The members of the panel were independent and had no prior contact with the subjects of the DHR or knowledge of the case.

The Overview Report author

The independent Chair of the panel and author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. During that time, he worked with victims of domestic abuse as part of his social work practice. He has held operational and strategic development posts in local authorities and the NHS. Before working independently, he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

Steve is entirely independent and has had no previous involvement with the subjects of the DHR. He has considerable experience in health and social care and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written a number of DHRs for local authority Community Safety Partnerships across the country. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation.

Steve has had no previous involvement with the subjects of the review or the case.

Terms of Reference

Terms of Reference were developed and agreed jointly. Panel members and the independent chair discussed these. The Terms of Reference were as follows:

- Consider the three-year period between January 2017 to January 2020, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant. Where such relevant information from outside the timeframe is available it will be taken into account.

- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.

- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

- Take account of the coroners' inquest in terms of timing and contact with the family.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Aim to produce the report within six months[1] after completion of the criminal proceedings, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.

- To discover if the perpetrator was subject to a Domestic Violence Protection Notice or Domestic Violence Protection Order.

- Were there any disclosures under 'Right to know' or 'Right to ask'.

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

[1] See mitigations relating to COVID and delayed trial on page 4.

- Was the victim known to local domestic abuse services, was the incident a one off or were there any warning signs. Could more be done to raise awareness of services available to victims of domestic abuse?

- Were there any barriers experienced by the victim or family, friends and colleagues in reporting the abuse?

- Consider the impact of any cross-border (local authority boundary) issues relating to access to services, service responses.

- Take account to and be cognisant of any ongoing review, for example the Independent Office for Police Conduct (IOPC) referral and review.

- Was abuse present in any previous relationships, did this affect the victims decision on whether to access support?

- Where there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?

- Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?

- Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children.

- Was the perpetrator known to have a history of domestic abuse, if so what support was offered to the perpetrator?

- Were staff working with the perpetrator confident around what service provision is available around domestic locally?

- Give appropriate consideration to any equality and diversity issues that appear pertinent to the perpetrator.

Key findings and conclusions

Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided, the panel has drawn the following conclusions:

The principle conclusion of the DHR panel is that Carol was subjected to domestic abuse in the period leading up to her death. This manifested itself through both previous coercive and controlling behaviour as well as physical abuse.

Coercive control is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour. The inclusion of coercive control in statutory legislation is still relatively recent, only being included in Section 76 of the Serious Crime Act 2015. By its nature it can often be hidden from others, notably family and friends as well as professionals.

This case demonstrates that coercive control may not always be recognised as such by the victim. The lesson to be learnt is that work remains to be done to raise awareness of coercive control, encouragement to victims to recognise and report it, and for agencies to respond to it appropriately.

The agencies that had contact with Carol treated her with respect and their inputs. However, not all interactions and interventions provided were in line with relevant policy and guidance.

Carol appears to have moved addresses frequently. It is understood that she resided in both privately owned and rented accommodation as well as that provided by local authority housing services. She also resided temporarily with members of her family at certain times. There is no evidence that these moves had any direct impact on the ability of agencies to offer or provide responses or services to her.

There is a significant amount of information that confirms that Carol was subjected to domestic abuse over a sustained period and by a number of her previous partners, before and including Colin. She had been in relationships with seven different men between 2007 and January 2020 when she was killed. Two of those former partners were the fathers of her children. In each of these relationships domestic abuse had been recorded at least once with each of those men.

A common theme to have emerged is Carol's reluctance to expose what was happening within her relationships. She was clearly reticent to reveal what was really happening in her life and in the view of some professionals this created barriers in being able to support her. Whether this is because she feared the consequences for herself or that she did not recognise the abuse as such is harder to quantify.

There was a willingness to accept the lack of perceived co-operation or wish for support and so referrals were closed at the earliest opportunity, indicating that there was no appetite for exploring further evidential opportunities.

There is clear evidence that agencies undertook appropriate risk assessments in relation to Carol. A Domestic Abuse Stalking and Harassment risk assessment (DASH) was used on a number of occasions and recognised risk ratings were applied. These were reviewed and amended where the evidence indicated that this was necessary, primarily by the police. The risk rating was raised where appropriate. However, the outcomes of those DASH assessments were not always shared between agencies, notably between the two constabularies.

Police referrals to the Cambridgeshire Multi Agency Safeguarding Hub (MASH) were all timely and accurate. There were delays in the processing of referrals by the Multi-Agency Referral Unit (MARU) and the MASH. The delays were in the recording and referrals to other agencies, although these were not detrimental and were due to a significant increase in all types of safeguarding referrals on the occasions experienced.

Colin had a history of domestic abuse offences. Both Suffolk and Cambridgeshire police were aware of Colin's history of offending through recognised information and intelligence networks. They involved breaches of a non-molestation order, breaching a suspended sentence for a domestic abuse offence and breaching a restraining order. He was therefore a known offender with a history of perpetrating domestic abuse.

A key theme to emerge from this DHR is the reluctance of Carol to support police action against her perpetrators. Although there is information that suggests she did, at times, recognise that she was subjected to domestic abuse, there is also evidence to indicate that her attempts to minimise it, not report it, or not support police action was borne of her concern about the possible consequence. Not least of these is the potential concern about the implications in relation to her children and the possible intervention of Children's Services. This had a direct impact on the ability of the police in particular to take forward criminal proceedings.

There are many reasons why an individual may not immediately make a report of domestic abuse. It may not be apparent to the victim that a relationship is abusive.

They may be afraid of the abuser, and fear the consequences for themselves or others if they disclose the abuse. The victim may not know where to turn for help.[2] They may also fear for the implications on their children, for example their removal by statutory services.

Carol's delay in making a formal allegation against a previous partner, known in this report as Trevor, did weaken the totality of her allegations but there were also evidential weaknesses that impacted on the decision-making. She was not considered to have been an unreliable witness but her reluctance to report and progress the incidents at the time, the varying versions of events that she gave and the other occasions that had gone unreported, impacted considerably.

The evidential weaknesses that undermined the case were identified within the reporting of the case by the police to the CPS, although the police did seek a prosecution decision to be made. The police must present a balanced case and the weaknesses seemingly influenced the decision by the CPS not to prosecute. The CPS do not suggest victim blaming, rather the focus is to the inherent evidential difficulties that undermine the case.

A delay in reporting does not diminish the impact of the abuse, nor should it be considered as a failure on the part of the victim. However, the evidential test still has to be applied. The police did not challenge the decision of the CPS not to prosecute, which was based on the evidential test.

There is no evidence that there were any organisational or systemic barriers to reporting of domestic abuse present in this case.

There was appropriate consideration of the needs and welfare of Carol's children. CSC were engaged in proceedings relating to their care and these resulted in Carol no longer having care or custody of them. On the majority of occasions that meetings took place Carol was invited but did not attend. There is no evidence to indicate that any follow-up was done to explore why she did not attend, and what steps were considered to ensure she was present so that she was engaged in those discussions.

The nature of the relationship between alcohol misuse and domestic abuse was recognised but the conclusion of the DHR is that it was not adequately considered or addressed. The misuse of alcohol can place individuals at greater levels of risk in relation to physical and mental health, their financial circumstances and their relationships, as such the Institute of Alcohol Studies suggests that it can increase an

[2] Safe Lives https://safelives.org.uk/policy-evidence/about-domestic-abuse/how-long-do-people-live-domestic-abuse-and-when-do-they-get Accessed March 2021

individual's overall risk and also in some cases their own vulnerability. Carol did not seek support from her GP for substance misuse, but it is not known if this was due to concerns about their being a formal record of this and its implications in relation to her children.

Research to indicate that alcoholism and drug abuse causes domestic violence is limited but that which exists indicates that among men who drink heavily, there is a higher rate of assaults resulting in injury. [3] Evidence suggests that alcohol use increases the chance and gravity of domestic violence, showing a direct correlation between the two. Because alcohol use affects cognitive and physical function, it reduces a person's self-control and lessens their ability to negotiate a non-violent resolution to conflicts.[4]

EEAST did not raise a safeguarding concern in respect of Carol's daughter. This is because she was not resident with Carol at the time of their attendance. However, changes have been made to the pathway for raising such a concern. This was not done as a result of Carol's death, but means that now a check will be made in relation to children who may be related or known to a patient being attended by the service. This shows that the service is continuing to review and improve local practice and process.

There is no evidence that the cross-border nature of this case had any direct impact on the immediate response of local services, in particular of the two constabularies that had contact with Carol. However, Suffolk and Cambridgeshire police did not always communicate effectively with each other, especially in the sharing of DASH risk assessment outcomes.

Recording of contacts and interactions with Carol by the agencies covered by this DHR were largely of the standard that would be expected. There were some gaps identified but there is no evidence that these had any detrimental impact on the response to Carol. However, accurate and timely recording remains something for all agencies to ensure takes place.

The use of recording systems to ensure that communications between professionals and agencies is critical in making sure that these interactions are known and that all involved have an up to date picture. These should be based on existing sharing agreements and the consent of the individual. This DHR has shown that there were some inconsistencies in both the recording of contacts and communication. These specifically related to contradictions about the contact between the MIU and the GP

[3] Very Well Mind – international online research library accessed February 2021
[4] American Addiction Centers alcohol.org accessed February 2021

practice. Such contradictions serve to hinder reviews such as this and can lead to omissions of knowledge.

The impact of the domestic abuse against Carol must have had an impact on her children, in particular her elder child. Although there was a period when neither of her children were living with her, her daughter in particular was exposed to the impact of the domestic abuse against her mother. CSC did take appropriate steps to safeguard Carol's children in the period covered by this DHR, but what further support either her daughter or son may have received is not known.

This case is one where the victim was subjected to domestic abuse by a number of partners over a significant period of time. While agencies did their best to offer support and help, their efforts were constrained by her reluctance to report, engage and work with those agencies. The DHR has highlighted some of the reasons for this. These only serve to reinforce the need to ensure that agencies prioritise the recognition of and response to domestic abuse. In particular in relation to women who experience multiple incidents and put in place strategies that can enable them to better recognise abusive behaviour, to report it and feel supported in the pursuance of action against perpetrators.

Lessons to be learnt

Domestic abuse and violence (DVA) is highly prevalent, particularly among women.[5] It accounts for 11% of all crimes reported to police in England and Wales, and more than one in four women and around one in six men have experienced DVA since the age of 16. However, official figures are likely to be an underestimate, because much DVA remains hidden.[6]

It is widely acknowledged that asking individuals about their experiences of domestic violence and abuse is more likely to encourage disclosures.[7] "It has been found that routinely asking women about domestic violence is more appropriate than an 'ad hoc' enquiry that may rely on stereotypical views around which groups of women are likely to experience domestic violence. Routinely asking gives the message that it is acceptable to disclose domestic violence and that no one is being specifically targeted for enquiry (which could have safety implications)"[8] Routine Enquiry is simply finding a way of asking people directly and confidently about DVA.

Given that on average high-risk victims live with domestic abuse for 2.3 years and medium risk victims for 3 years before getting help[9], the use of routine enquiry can be an effective method, not only in identifying domestic abuse, but doing so more swiftly than might otherwise be the case.

Despite her reluctance to engage, there were programmes that Carol could have been more proactively directed to. These included the Freedom Programme, which might have assisted her in being able to recognise abusive behaviours. While it is important to state that it is not possible to compel a person to engage or participate, being able to clearly articulate the benefits of such a programme, including the online version could usefully form part of the work of the IDVA services locally.

[5] Routine enquiry for domestic violence and abuse in sexual health settings, Lyus, L. & Masters, T. British Medical Journal http://dx.doi.org/10.1136/sextrans-2017-053411
[6] ibid
[7] Piloting Routine Enquiry in Leeds GP Practices 2016 https://www.leeds.gov.uk/domesticviolence/Documents/GP%20Pilot%20Report%202016%20Final.pdf
[8] Domestic violence in work with abused children, Hester, M. and Pearson, C. JRF 1998
[9] SafeLives Insights Idva National Dataset 2013-14. Bristol: SafeLives 2015

Recommendations

The Domestic Homicide Review Panel made the following recommendations arising from the review. They were developed in direct response to the key findings and conclusions. The full Overview Report describes the linkages between the findings and recommendations in more detail.

1. Suffolk polices' processes for information sharing have developed and evolved through operational practice. Suffolk police should undertake a process of work to ensure that their processes for information sharing and cross-border working with colleagues in Cambridgeshire are robust and operationally effective in relation to domestic abuse. They should provide assurance to the CSP within six months of this report being approved by the CSP. They should conduct an annual review of these arrangements.

2. Cambridgeshire polices' processes for information sharing have developed and evolved through operational practice. Cambridgeshire police should undertake a process of work to ensure that their processes for information sharing and cross-border working with colleagues in Suffolk are robust and operationally effective in relation to domestic abuse. They should provide assurance to the CSP within six months of this report being approved by the CSP. They should conduct an annual review of these arrangements.

3. Suffolk police should review their practice in relation to the use of the provisions of both DVPN's and DVPO's to ensure they are well understood by officers and effectively used. They should share their practice and learning with colleagues in Cambridgeshire as a means of promoting collaborative learning and development.

4. Cambridgeshire police should review their practice in relation to the use of the provisions of both DVPN's and DVPO's to ensure they are well understood by officers and effectively used. They should share their practice and learning with colleagues in Suffolk as a means of promoting collaborative learning and development.

5. Although there was an understanding of issues relating to safeguarding and how to raise concerns, the panel was of the view that there would be benefit in highlighting the need for greater understanding of different organisational processes and when to raise a concern. In particular safeguarding, although considered, did not always appear to be a process, which would necessarily have led to any greater or more effective action to reduce risk to Carol. Local practice should be reviewed and compared with other similar local authority areas to determine where and how current processes, understanding and practice in safeguarding, both adults and children, can be improved.