June 2014

Domestic Homicide Review

Executive Summary of the Overview Report

into the death of Miss A
12th September 2012

The Panel send their condolences
to the family of Miss A

B Higgs

Independent Panel Chair and Author

1. Introduction

This Domestic Homicide Review (DHR) was commissioned by the Safer Somerset Partnership following the tragic murder of Miss A on 12th September 2012.

1.1 Case Summary

Miss A was murdered at home by her partner Mr X on the 12th September 2012. His ex/current girlfriend Miss Y and her uncle Mr XY then removed the body from the scene and created a car fire in a secluded location. This was to provide 'evidence' for a cover story for the murder that had been pre-meditated and planned in meticulous detail by the three perpetrators for months in advance. The motive was financial gain, namely a half share in the property the couple had purchased together and a claim on her life insurance policy.

1.2 The background:-

At the time of her death in September 2012 Miss A was 23. A hard working and determined student she had attained a first class honours degree in Business Management from Bath Spa University in 2011. She was working in her first post-graduate role as a Business Analyst for a large international manufacturing company in her local town. Miss A's mother, father, sister, grandmother, aunt and cousin all work at the same company.

Miss A is from a close knit family who were very proud of her achievements. She was known to be good natured, fun, loving, independently minded and loyal.

Miss A first met Mr X who was to become her partner working her university vacation on the production lines of the manufacturing company in the summer break of 2010. On her return to university the relationship continued and they were considered a couple by Christmas 2010. In January 2011 Miss A returned to university to complete her final semester. On her return she split her time living between Mr X's flat and the family home. This could be described as Miss A's first serious relationship. There had been one other relationship that had lasted approximately 6 months.

Miss Y, Mr X's former girlfriend went to extreme lengths to split the couple up. On one occasion she staged an incident that purported to show that Mr X was in bed with her and then called Miss A to come and see. This event led to Mr X losing his temper. He was charged with Common Assault against Miss Y.

Miss A and Mr X did split up for a short time after this incident but the relationship resumed in the Autumn of that year. By the time of the court

case in January 2012 Miss A and Mr X's relationship was on a serious footing. Miss A supported Mr X in court as did her family. Both Miss A and Miss Y had tried to retract their statements just days after the incident but both appeared as witnesses in court. Mr X received a 12 month restraining order preventing contact with Miss Y.

A few days prior to the trial there had been threats to Miss Y allegedly by Mr X in breach of his bail conditions. After the trial Miss Y contacted Miss A to try and recover money apparently owed by Mr X. Miss Y was warned not to contact Mr X and to refrain from involving Miss A.

In February 2012 Miss A and Mr X were assisted by her family to purchase a property together. To all intents and purposes they looked to everyone like a young couple in love and starting out in life together. They were outwardly affectionate and no-one expressed any concern for Miss A.

By April 2012 Mr X was back in contact with Miss Y. Certainly by May there is firm evidence that the complex plot to murder Miss A and claim on her life insurance and claim ownership of her half of the house was underway. The criminal investigation evidenced numerous meetings and hundreds of texts and phone calls between the three perpetrators. Miss A seemed to have been blithely unaware that Mr X was in a relationship with Miss Y. A false trail of texts and internet profiles were set up by the three perpetrators to a) show that Miss A was in contact with a former boyfriend and b) that she was promiscuous and posted information about herself onto internet sites that contained sexual content.

The murder took place in the early hours of 12th September 2012.

Mr X went to work as normal as his co-conspirators followed the plan to cover up the murder and provide false motive.

2.0 The Review Process

This summary outlines the process undertaken by the Domestic Homicide Review Panel.

2.1 The review has been conducted outside of the normal timescales for a DHR. Key factors that contributed to the delay include:

- Delayed police notification to the Safer Somerset Partnership
- An initial decision not to conduct a DHR

2.2 Following communication with the Home Office and new case information this decision was subsequently reversed and the Domestic Homicide Review commenced in November 2013. It has been conducted in line with section 9 of the Domestic Violence, Crime and Victims Act 2004 and the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (revised August 2013). The overview report has been prepared in accordance with the Home Office guidelines (January 2012
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2.3 The process began with an initial Review Panel Meeting on 18th of November 2013 of the agencies that potentially had contact with the victim or perpetrators. Further panel meetings took place. The Panel Chair also met with the family of Miss A on two occasions prior to the production of the overview report and once afterwards. Two of the perpetrators were invited to contribute but declined. The Panel chair was also briefed by the DCI SIO in charge of the murder investigation.

The employer of Miss A played a significant and helpful role in facilitating the interviews with family members and colleagues during the preparation of the report.

At the conclusion of the Review they were informed about the lessons learned and recommendations made.

2.4 At the conclusion of the Review the victim's family and the other contributors were shown the completed overview report.

2.5 Agencies Contacted

The following agencies were contacted about this review but found either *no contact* or *minor contact* with either the victim or perpetrators on their records:

Avon & Somerset Constabulary
Avon & Somerset Probation Trust
IDVA/Bournemouth Churches Housing Association
Midwest European Community Association
Somerset Partnership NHS FoundationTrust
South Somerset District Council
Somerset Safeguarding Adults Board
Turning Point Drug and Alcohol Partnership
Victim Support
NHS Foundation Trust Yeovil District Hospital
Taunton & Somerset Foundation Trust NHS Musgrove Hospital
Somerset Clinical Commissioning Group

2.6 The only agency required to undertake an IMR was the Avon & Somerset Constabulary, there being no significant contact with any other agency. The purpose of the IMR was to:

- Provide a chronology of involvement with Miss A, Mr X, Miss Y and Mr XY during the time period specified
- Search all of their records including outside the identified time period to ensure no relevant information was omitted
- Provide an IMR: identifying the facts of their involvement with those identified, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.
- It was also specifically requested that good practice was highlighted

The specific purpose of the Individual Management Review (IMR) contained in the overview report is to provide accurate information concerning previous police contact with the three perpetrators, the victim and her family. This information provides important timeline information and insight into the relationship dynamics between the individuals leading up to the homicide itself. It considers the police response, evaluates it fairly, and identifies improvements for future practice.

The IMR report received was of good quality and questions arising were answered promptly and in full. The IMR has been signed off by a responsible officer in the organisation who will also maintain the strategic ownership of the individual agency action plan.

Recommendations forthcoming from the IMR report have been included in the action plan.

3.0 Terms of Reference

The purpose of the Domestic Homicide Review is to:

Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

Establish what lessons are to be learned from the case about the way in which local professionals and organisation work individually and together to safeguard and support victims of domestic violence including their dependent children.

Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

Apply these lessons to service responses including changes to policies and procedures as appropriate; and prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.[1]

Specific aims of this review were to:

- summarises concisely the relevant chronology of events including the actions of all the involved agencies;
- analyses and comments on the appropriateness of actions taken;
- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, particularly those who are older and anyone who may also experience mental health problems or a disability or other chronic ill-health

3.1.0 The review considered the following questions

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

3.1.2 Whether Miss A or any of the perpetrators had any known contact with any specialist domestic abuse agency or service in the County. The review considered if there were any warning signs which were not acted upon.

3.1.3 Whether family, friends, colleagues, employer, wanted to participate in the review. If so, find out if they were aware of any abusive behaviour by the

[1] Paragraph 3.3 Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

perpetrator prior to the homicide.

3.1.4 Whether, in relating to family members or colleagues, were there any barriers to reporting suspected abuse.

3.1.5 Could improvement of the following have led to a different outcome for Miss A:-

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

Whether any organisational policy, training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

3.1.6 Whether the work undertaken by the service in this case is consistent with its own

(a) Professional standards

(b) Compliant with its own protocols, guidelines, policies and procedures

3.1.7 Whether the agency was sensitive to the Equality Act 2010 including age, disability, gender reassignment, marriage/civil partnership, pregnancy and maternity, race, sex, sexual orientation, religious belief and specialist needs on behalf of the subjects were properly considered and appropriate actions taken and recorded.

3.1.8 Any other information that becomes relevant during the conduct of the Review.

3.2 There were no parallel reviews or investigations taking place at the outset of this Review

3.3 This DHR was conducted within the principles of Equality and Diversity and was conducted with of fairness, openness and transparency.

4.0 Key Issues

The DHR panel considered all the information obtained from the Avon & Somerset Police and from family and friends.

The core issues reviewed include

- The perpetrators history of behavior, particularly Mr X and Miss Y, to evaluate to what extent the outcome was predictable, including previous criminal convictions.

- The nature of the previous relationship between two of the perpetrators that led to the Common Assault DV trial and subsequent restraining order of January 2012. To evaluate if this incident was predictive.

- Whether there were any indications noted by family or friends in the relationship between the victim and the perpetrator that would have predicted or could have prevented the final outcome.

5.0 Lessons Learned

5.1.0 The Safer Somerset Partnership does not have a dedicated website or web pages on the SCC site. This would be useful for agencies, the public and others to access relevant up to date statistical data and general information relating to local services relevant to safeguarding adults and children or links to other sites providing that data.

5.1.1 The Safer Somerset Partnership and individual agencies should consider engagement with large local companies as an effective route for people to access information about local specialist services in the workplace.

5.1.2 GP surgeries are overwhelmed with information and literature. Consideration should be given as to how to make specialist local information concerning DVA stand out and to ensure it is prominently displayed. See general recommendations.

5.1.3 Not all GP surgeries have a named DVA lead. This should be the case.

6.0 Conclusions

6.1 In reaching the conclusions in this review focus has been on the following questions

Has the agencies involved in the DHR used the opportunity to review their practices, policies and procedures and contacts with the victim and perpetrators to openly identity and address the lessons learnt?

Will the recommendations in the Review improve the safety of domestic abuse victims in the County in the future?

Was this death predictable?

Could this death have been prevented?

This review commends the manner in which the A&S Police undertook the review. It was cooperative and the information gathered far reaching and thorough. Subsequent questions were addressed in a timely manner and in full. The recommendations will aid the development of working practices that may assist future cases.

The recommendations in this report will aid the already considerable work that is underway to maintain a high awareness of local specialist services.

6.2 Was this death predictable or preventable?

After consideration of the information available the review panel does not believe that this homicide was either predictable or preventable, falling into the 'highly unlikely' category.

Family, Friends and Colleagues

At the time of the murder there was absolutely nothing that forewarned or prepared Miss A's intimate or wider circle of family and friends for what happened.

Although the family had reservations about how long the relationship would last there were no real concerns. On reflection the victim's father thought that Miss A would outgrow the relationship sooner rather than later and the victim's mother thought that eventually Miss A would want to go to London and pursue her early career promise and ambition. But for the meantime all

seemed well, family and friends observed a loving couple enjoying life. Miss A was very happy and the family supported the relationship.

It would be difficult to overstate the impact this murder has had on those closest to the victim and the wider communities of her workplace and town. Throughout the review process family and friends interviewees have used words such as ‘betrayed’, ‘shocked’, ‘devastated’ ‘duped’, ‘tricked’, and ‘unbelievable’.

Over time it is understandable and natural that people re-examine memories of conversations, incidents and behaviours over and over again to try and make sense of circumstances that make no sense at all. Once re-interpreted and re-assembled could these ‘facts’ if put together give an indication that this homicide was predictable or preventable? No-one believes this is the case.

Police and GP contacts for both victim and perpetrators could be described as low level and normal respectively and did not predicate homicide. There were no actions that could have been taken that would have prevented the outcome.

The key to this murder is the relationship formed between Mr X and Miss Y. Nothing in the known history of either Mr X or Miss Y as individuals suggested they were a significant threat to anyone. Tragically, in a phenomenon not unknown in criminological history, the combination of their personalities in an intimate personal relationship created a dynamic that made them dangerous and capable of calculated, meticulous pre-meditated murder, in this case, in pursuit of financial gain.

7.0 Recommendations

7.1 The Avon & Somerset Constabulary identified two recommendations

1. It has been recommended that there should be increased requests by police officers for ACRO[2] checks on foreign national suspects, witnesses and victims. Although these checks are currently available the recommendation includes measures to increase awareness and use by police officers and CPS lawyers such as awareness training, and internal publicity. This recommendation would not have had an impact on the outcome of this case

2. A recommendation that a system is put in place to ensure that STORM logs are closed with an appropriate supporting rationale if no Guardian crime or incident report is to be raised. Measures were already in place to implement this recommendation and have since been enacted. Logging and recording issues noted in this case are unlikely to arise in the future. Again this recommendation would not have had an impact on the outcome of this case

7.2 Panel Recommendations

Avon & Somerset Police

The Avon & Somerset Constabulary must ensure that all complaints of witness intimidation are thoroughly investigated. It is crucial that the police enforce this serious offence. First to protect witnesses and to ensure witness cooperation. Secondly to protect the integrity of judicial proceedings and the judicial system. It cannot be asserted that this recommendation if followed would have changed the outcome.

Somerset Clinical Commissioning Group - GP Surgeries

On visiting the victim's surgery it was noted that although Miss A's GP surgery has a wealth of literature and posters information concerning access to local specialist services, those for DVA were largely absent in the three waiting areas. Although unlikely to have made a difference to the outcome of this case, this observation gives rise to the following general recommendations.

[2] Association of Chief Police Officers Criminal Records Office

The panel recommends that the Somerset Clinical Commissioning Group writes to all GP practices urging them to regularly check waiting areas to ensure that DVA resources are available and given priority space. This communication should be addressed to the Senior Partner, Practice Manager and named DVA Lead if known.

That each GP practice is adopts the policy of having a named DVA GP lead.

The panel recommends that the Somerset CCG recommends to GP Practices that they are familiar with both CAADA and the RCGP websites that have good guidance on responding to domestic violence and GP e-learning. NICE guidelines published February 2014.

The Employer

The employer has engaged with the Panel Chair and is exploring a range of options that will better inform the staff of available specialist services available locally concerning a wide range of social issues. The SSP will evaluate whether liaising with other large companies in the area is a worthwhile route to disseminating information about local specialist services.

The Family

The Panel Chair has spoken to members of the family and given information about other organisations that may assist them including AAFDA and Escaping Victimhood.

SSP/SCC

Review the existing SCC website with a view to including either an easily accessible central direct point of information or links to DVA data in Somerset.

To include

- An overview of the DHR process and links to published DHR reports.
- Reviews, audits and inspections of services related to Somerset DVA services e.g. HMIC's review of Avon & Somerset Constabulary's approach to tackling domestic abuse (2014)
- Current statistics and data captured by organisations such as the Avon & Somerset Police, Somerset Intelligence Network (SINE) and voluntary sector (eg BCHA), Somerset Survivors.
- Relevant SCC policies and reports e.g. Somerset Interpersonal violence strategy
- Downloadable literature and resources relating to national and local specialist DVA services including leaflets and posters in English and other languages
- Links to relevant websites as below such as www.**somersetsurvivors**.org.uk

8.0 Useful Websites

Advocacy After Fatal Domestic Abuse
http://www.aafda.org.uk/
Coordinated Action Against Domestic Abuse
http://www.caada.org.uk/
Escaping Victimhood
http://www.escapingvictimhood.com/
RCGPhttp://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Domestic%20Violence/IRIS-Commissioning-Pack-January-2014.ashx
Somerset Survivors
www.somersetsurvivors.org.uk
Equality and Human Rights Commission
www.equalityhumanrights.com