Report of the
Epping Forest
Domestic Homicide Review Panel
Into the Death of
G A
on
8 July 2012

Report produced for the community safety PARTNERSHIP EPPING FOREST DISTRICT

By Ann Haigh B.A. (Hons.), CQSW

Date: 22 November 2013

Definition of Domestic Violence

The government definition of domestic violence and abuse was recently extended to include young people aged 16 and 17. Wording was also included to capture coercive control. The new definition, which was implemented from 31 March 2013, 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:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."*
*This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

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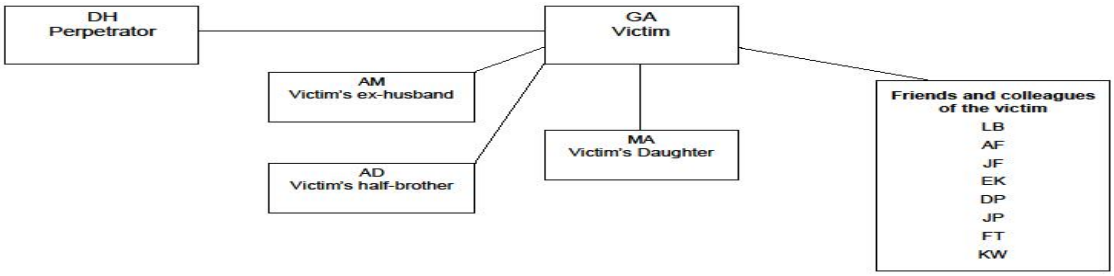
Executive Summary

1. The Review Process

The following diagram shows the individuals who are referred to throughout this report and the initials which have been used to identify them.



1.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This came into force on 13 April 2011.

1.2 This summary outlines the process undertaken by the Epping Forest Domestic Homicide Review Panel in reviewing the murder of GA. At the time of her death, GA was a 39 year old single mother, who lived with her daughter MA, then aged 9 years, in Essex. She had separated from her husband, AM, in 2009 and met DH (the perpetrator) in April 2012. Statements from friends and colleagues describe an intense relationship which developed over a short period of time between April 2012 and July 2012. They initially appeared to get on well but, by early June 2012, their relationship had rapidly begun to deteriorate.

1.3 On Saturday 7 July 2012, GA and DH went out separately in the Loughton area, but ended up together later in the evening. They went back to DH's Loughton address, where he rented a room. At 4.34am the next morning, GA received a text message from a man she had met in April 2012 but had not seen since. DH apparently saw the text but believed it had come from GA's personal trainer, who he thought she was seeing behind his back. This was the catalyst for the argument which ended with DH stabbing GA in the back and chest.

1.4 At 6.36am on 8 July 2012, Essex Police received an emergency call. Police officers attended the address, where they found GA's body. The Essex Ambulance Service attended the scene and GA was pronounced dead. DH was located near to the scene and, following a violent struggle, was arrested on suspicion of murder.

1.5 The Panel was faced with the complication that DH had only lived within the District for just over a year and was previously known to three separate Police Forces, two Probation Trusts and three Health Trusts. These agencies were based across both England and Scotland

1.6 From the original scoping exercise for the review, 22 agencies out of a total of 55 that were contacted, responded with information indicating some level of involvement with the victim or the perpetrator. Agencies were asked to give:

- A chronology of involvement with GA and/ or DH, including what was done and what was agreed.
- Whether the agency's internal policies and procedures were followed, together with conclusions and recommendations

1.7 Of the ten agencies that responded with information regarding GA, only Dumfries and Galloway Police had records of recent contact with her prior to her death

1.8 Prior to her death, the only contact which the victim had with Essex Police was in January and May 2010, when she reported domestic abuse incidents involving her ex-husband, AM. At the time, these were assessed as medium and standard risk and no other agency referrals were made. GA was not known to any domestic abuse services in either Epping Forest District or Essex.

1.9 In respect of DH, Essex Police had no record of contact prior to the murder of GA. However, sixteen of the 22 agencies which responded with information indicated some level of involvement with DH and six of the agencies had records of considerable engagement although some of this was historic, dating from 1985 through to 2003.

1.10 Following the conclusion of the court case, family and friends of the victim were contacted to explain the purpose of the DHR and asked whether they would assist the Review Panel. Only one accepted that invitation, that being the victim's half brother, who willingly provided some background information through a personal interview with the Review Panel Chair.

1.11 At all times, the Panel was sensitive to the needs of the victim's daughter, aged 9, as she was not of age to consent to the release of material relating to her education and health records. In compiling this report, the Panel recognises that as she matures, she may wish to have access to the report.

1.12 The Panel discussed whether the perpetrator should be interviewed as part of the DHR process. It was concluded that this would be of no benefit to the review process.

2. The Scope of the Review

The following issues were considered by the Review Panel:

Were relevant agencies aware of the circumstances of the victim and alleged perpetrator and, if they were, what actions were pursued or offered?

Had the victim or perpetrator disclosed to any agency and if so what was their response?

Did agencies undertake their responsibilities in accordance with agreed protocols?

To what degree could the homicide have been anticipated and therefore prevented?

What were the key points or opportunities for assessment and decision making in this case?

Were there ways of working effectively that could be passed on to other organisations or individuals?

3. Key Points Arising From the Review

3.1 During the last month of GA's life, there were indicators that DH's behaviour was escalating and becoming increasingly dangerous and threatening towards her. During this period, GA disclosed a number of incidents separately to various friends and colleagues.

3.2 The only incident between GA and DH which was reported to Police took place in Scotland on 10 June 2012 and was dealt with by Dumfries and Galloway Police. However, a PNC check failed to identify that DH had an extensive criminal history and this was therefore not a factor considered when the VPR and SPECCSSS risk assessment form were completed.

3.6 On the day after the incident at the caravan park (11 June), Dumfries and Galloway Police emailed the VPR and SPECCSSS form to Essex Police. Unfortunately the e-mail was deleted without being opened and Essex Police have been unable to identify who was responsible.

3.8 In dealing with the information obtained from the incident in Scotland, both Dumfries and Galloway and Essex Police did not fully implement procedures which were in place at the time, and some procedures were not sufficiently robust to flag up concerns.
3.9 In the period following 21 June 2012, DH exhibited violent behaviour on a number of occasions which were known to friends and other third parties. None of these incidents was reported to any relevant agency.

3.11 In the weeks before her murder, GA expressed to friends and some family members that she wanted to end her relationship with DH. At that point she felt she could handle the situation and AD reported that she wanted to "do this the right way" in order to avoid "setting him off". It was not until the last two weeks of the relationship that GA expressed concerns about her safety and, even then, from the evidence available, the Panel could not be certain that she fully appreciated the extent of the danger that she was in.

3.12 The statements from GA's friends revealed that the victim's daughter (MA) was present at a number of the incidents prior to the murder, and the Panel considered how this may have impacted on her welfare.

4. Conclusions

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The following conclusions have been drawn from the review process:

(1) There was only direct evidence of one recorded incident of domestic abuse between GA and DH in the period leading up to her murder, that being the incident in Dumfries and Galloway on 10 June 2012;

(2) Whilst there is anecdotal evidence via witness statements of friends of GA of the escalating levels of violence towards and intimidation of GA by DH, it is clear that neither GA nor her friends or family made any formal representations to the police or other agencies;

(3) Whilst it is clear that not all the formal information exchange protocols had been correctly followed in this case by the agencies involved, and had they been additional steps might have been taken, it appears very unlikely that these additional steps would have resulted in any action which would have prevented the murder taking place; and

(4) GA, despite the increasingly violent and intimidating behaviour of DH, took no steps to engage with the police or other agencies. Whilst this approach may well have been influenced by fear of reprisal by DH, she appeared to be of the view that she was able to manage the situation she was in. Unfortunately, this belief proved to be misguided.

(5) It was often difficult to know what information to ask for when the Panel did not know what was available.

5. Recommendations

5.1 Individual Agencies

Through the production of their IMRs, a number of agencies identified key areas for review and have made recommendations regarding future actions. These are set out below:

<u>Essex Probation Trust</u>

R1. The findings of Domestic Homicide reviews to be made available to relevant staff across the Trust.

R2. Relevant staff to be instructed to read the case files.

R3. An accurate Risk of Serious Harm to be completed and retained on the case record. This must take into account the offender's previous convictions and other relevant material from the case file.

R4. No violent offender to be assessed as low risk of harm without the endorsement of a manager.

R5. Requirement Officers to only hold singleton unpaid work orders which are assessed as low risk of harm.

Norfolk and Suffolk Probation Trust

R6. That the NSPT Procedure Note relating to the External Transfer of Cases to be revised to include instructions to staff to retain a skeleton hard copy file in all cases where the matter is transferred to another Trust.

Directorate of Schools, Children and Families, Essex County Council

R7. The Director of Learning to provide briefings and learning opportunities for schools and academies on the outcome of this review with a focus on the school role in identifying domestic abuse, the impact on children and protective factors.

East of England Ambulance Service

R8. Details of service users to be recorded by name and gender in all ambulance attendances

5.2 Recommendations from the Review Panel

The Review Panel considered the recommendations outlined above from some of the agencies who produced IMRs, and endorses them. In addition, the Panel has considered what additional recommendations arise from the review process overall, and these are set out below.
The Review Panel recommends as follows:

The IMR supplied by Loughton Health Centre identified that the practice was not aware of any previous domestic abuse issues and the perpetrator did not disclose any issues. Accordingly, the practice was unaware of any wider concerns that may have been relevant to the treatment and referral decisions made. It is therefore recommended:

R9. that all agencies share domestic violence reports with both the victim's and the suspected perpetrator's GP.

The IMR supplied by the Traps Hill Surgery identified a training need for their medical and administrative staff and the review panel felt that this could reflect a wider training requirement. It is therefore recommended:

R10. that all GP practices undertake a review of the training provided to their medical and administrative staff.

Further general recommendations of the review panel

R11 A common system be developed for all relevant agencies to allow third party reporting of domestic abuse.

R12. Immediate action be taken to improve safeguarding training relating to domestic abuse in schools and colleges

R13 That the practice of co-locating of police, domestic abuse, child abuse, and adult abuse staff with professionals from Children's Services, Advocacy, Health and Probation in the Multi-Agency Safeguarding Hub (as is the practice with the Norfolk Constabulary) be considered for adoption countrywide.

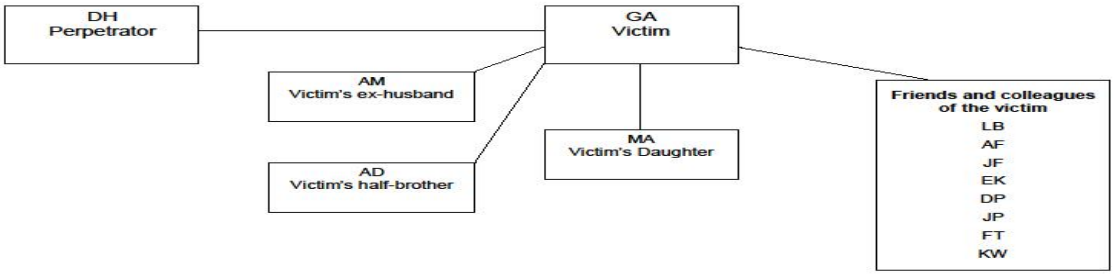
R14. A member of the police investigating team to attend a review panel meeting at the earliest opportunity after the legal proceedings had been completed,

The action plan set out as appendix B is intended to take the above recommendations forward.

2. Introduction

Preface

The following diagram shows the individuals who are referred to throughout this report and the initials which have been used to identify them.



2.1 The purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Seek to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working; and
- Produce a report in a timely manner subject to 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

2.2 The review arose from the killing of the victim (GA) by the perpetrator (DH) on 8 July 2012.The review was carried out in compliance with the relevant legislation (Section 9 of the Domestic Violence, Crime and Victims Act (2004), which came into force on 13 April 2011) and follows the guidance issued by the Home Office. There were no other reviews conducted or combined within this or any other report. The Panel determined that there were no ethnicity, culture, faith, sexual orientation, disability, gender or other diversity issues that had a bearing on agency involvement in respect of this particular DHR.

2.3 In conducting the review, the Panel recognised the complex emotions the family members must have experienced. A young woman died, a child lost her mother, a mother lost her daughter and a brother lost his sister. Her ex-husband is parenting their daughter; all have experienced pain and loss. The members of the Review Panel have conveyed their sympathy to the victim's family and have endeavoured to undertake their task sensitively.

2.4 The interview with the victim's half-brother enabled the Panel to obtain a profile of her as an individual, not just as a victim of a crime. He also spoke of the positive support he received from Victim Support and from the Essex Police Major Crime Team, who led the investigation. The Panel would like to thank him for his willingness to engage with the review.

2.5 The Chair of the Panel would like to take this opportunity to thank all the Panel members and their respective agencies who co-operated with the review, in particular Epping Forest District Council, who provided accommodation and administrative support for the DHR, with special thanks to Caroline Wiggins – Safer Communities Manager.

Membership of the Panel

2.6 The Membership of the Review Panel was as follows:

Name	Position / Organisation
Ann Haigh	Independent Member and Chair
His Honour Anthony Bradbury	Independent Member. Retired Circuit Judge
Cllr Gary Waller	Chairman of Epping Forest Community Safety Partnership
John Gilbert	Director of Environment & Street Scene Epping Forest District Council
Jim Nolan	Assistant Director of Environment & Street Scene Epping Forest District Council
Caroline Wiggins	Safer Communities Manager Epping Forest District Council
Colleen O'Boyle	Director of Corporate Support Services / Solicitor to the Council Epping Forest District Council
Chief Insp. Denise Morrissey	Essex Police
Ioan Gherendi	Essex Probation Trust
Ben Hughes	Essex Drug and Alcohol Action Team (DAAT)
Val Billings	Essex Safeguarding Adults Board Essex County Council
Paula Ward	Essex Safeguarding Adults Board Essex County Council
Jan Dalrymple	Safer Places, Harlow
Sheona Siewertsen	Lead for Safeguarding Adults West Essex Clinical Commissioning Group
Siobhan Jordan	West Essex Clinical Commissioning Group

2.7 Following the appointment of the Panel, the Community Safety Partnership sought to appoint an independent Chair. John Gilbert, Director of Environment and Street Scene at Epping Forest District Council and Cllr Gary Waller, Chairman of Epping Forest Community Safety Partnership interviewed Mrs Ann Haigh B.A.(Hons.) C.Q.S.W. Mrs Haigh is a former Chairman of Epping Forest District Council, who has many years of experience of family work, including domestic violence, as a social work practitioner and manager, Children's Guardian, trainer and consultant. She was also a member of the Court Rules Advisory Committee for the Children and Families Bill. Mrs Haigh has not been an elected member of either the district or county council for over 5 years and has no ongoing role with either authority.

2.8 Following the interview, Mrs Haigh was invited to join the Panel as an independent member. At the initial meeting of the Panel on 1 October 2012, Mrs Haigh was unanimously accepted onto the Panel and appointed as Chair.

Timescale

2.9 This review began on 26 July 2012 when the Home Office was advised by Cllr Gary Waller, Chairman of Epping Forest Community Safety Partnership (CSP), that a DHR was required and would be conducted. The Panel was asked by Essex Police to defer any contact with family and friends until after all legal proceedings were completed. DH was sentenced on 15 February 2013 and it was at this point the Chair of the Panel contacted family and friends. The Essex Police Individual Management Review (IMR) was requested on 5 October 2012 but not received by the Panel until 21 February 2013, adding further delays to the production of this final Overview Report.

2.10 A copy of the sentencing remarks from Regina v D H, 15 February 2012, was requested by the Panel and received in late June 2013. This disclosed a previous incident of domestic abuse between GA and DH which was previously unknown to the Panel. On 23 July 2013, at the request of the Panel, Essex Police provided copies of statements from GA's friends and work colleagues, which allowed the Panel to have a much greater insight into the relationship between the her and DH during the period from April 2012 to July 2012 and the events immediately leading up to the murder. Although this delayed the completion on the DHR, the Panel agreed it was important to include the information contained within the statements.

2.11 The Panel advised the Home Office in January 2013 that the outcome of the Review would be delayed beyond the prescribed deadline of February 2013.

Circumstances leading to the Review

2.12 On 10 July 2012, Essex Police notified the Chairman of the Epping Forest Community Safety Partnership (EFCSP) of the death of GA. Following discussions between the Chairman and Essex Police, the Chairman concluded that the circumstances surrounding the death were such that it was appropriate to establish a DHR. It was to be undertaken in accordance with the requirements of the Domestic Violence, Crime and Victims Act 2004.

The Scope of the Review

2.13 The following issues were considered by the Review Panel through the receipt of Individual Management Reviews (IMRs) from relevant organisations and individuals:

(1) Were relevant practitioners and agencies in the various locations aware of the circumstances of GA and DH and if they were, what actions were pursued or offered. If they were unaware, had they reviewed their procedures or arrangements to determine whether they should have been aware, and had they taken steps to increase their levels of awareness and information gathering. Additionally, were they sensitive to the needs of the victim, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns;

(2) If the practitioners and agencies were aware of issues of concern in relation to GA and/or DH, what steps had been taken to address those issues. In particular did the practitioners and agencies have in place policies and procedures for dealing with domestic violence;

(3) Had GA and/or DH disclosed to any practitioner or agency and if so what was their response. In particular was GA subject to a Multi Agency Risk Assessment Conference (MARAC) or DH subject to a Multi Agency Public Protection Arrangement (MAPPA);;

(4) Did practitioners and agencies undertake their responsibilities in accordance with agreed protocols. In particular were those protocols properly applied and implemented and if so were they found to be effective;

(5) Were there any particular factors relating to this homicide which would require additional specialist input to assist in the review panel's deliberations, for example drug and alcohol misuse by the victim and alleged perpetrator;

(6) To what degree could the homicide have been anticipated and therefore potentially prevented ;

(7) What were the key points or opportunities for assessment and decision making in this case. Were assessments and decisions reached in an informed and professional way;

(8) Did actions or risk management plans fit with the assessments and decisions made;

(9) Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time;

(10) When, and in what way, were GA's wishes and feelings ascertained and considered;

(11) Was it reasonable to assume that the wishes of the victim should have been known;

(12) Was the victim informed of options/choices to make informed decisions. Was she signposted to other agencies;

(13) Was anything known about the perpetrator, for example, was he managed under MAPPA;

(14) Had the victim disclosed to anyone and if so, was the response appropriate;

(15) Was this information recorded and shared, where appropriate;

(16) Were there other questions that may have been appropriate and could have added to the conduct of the Review;

(17) Were there ways of working effectively that could be passed on to other organisations or individuals; and

(18) Were there lessons to be learned from this case relating to the way relevant agencies work to safeguard victims and promote their welfare, or the way they identify, assess and manage the risks posed by perpetrators? Where can practice be improved?

Review Methodology

2.14 Following the scoping exercise set out above, 22 agencies out of the total of 55 that were contacted, responded with information indicating some level of involvement with the victim and/or the perpetrator (see Appendix B for full details). Agencies were asked to give chronological accounts of their contact with GA and her family and /or DH. The DHR covered in detail the period from April 2012 until July 2012; however, some agencies also provided additional historical context where appropriate, from 1998. Each agency's report included:

(a) A chronology of involvement with GA and/ or DH, including what was done and what was agreed; and

(b) Whether the agency's internal policies and procedures were followed, together with conclusions and recommendations.

2.15 Following receipt of the information referred to in paragraph 1.14, the Review Panel decided whether an Individual Management Review (IMR) was required. A total of 10 IMRs were requested from the following agencies:

(1) (DH's employer);

(2) Police Scotland (officially recorded incident of domestic abuse);

(3) East of England Ambulance Service NHS Foundation Trust (called to the murder scene);

(4) Essex Police (murder investigation and any previous contact with GA and/or DH);

(5) Essex Probation Trust (contact with DH);

(6) Loughton Health Centre (perpetrator's GP practice);

(7) Norfolk Constabulary (DH's previous criminal record);

(8) Norfolk & Suffolk Probation Trust (DH's previous criminal record)

(9) St John's School, Buckhurst Hill (MA's school); and

(10) Traps Hill Surgery (GA's GP practice)

2.16 All IMRs were assessed by the Panel to ensure that content was appropriate and fit for purpose. IMR authors were, where relevant, requested to provide further information or to clarify matters raised.

2.17 Additional documents referred to included:

(1) Police officer statements (officially recorded incident of domestic abuse);

(2) The trial Judge's sentencing remarks from the DH's trial; and

(3) GA's friends' and colleagues' statements.

2.18 Interviews were conducted with Chief Inspector SC (Police Scotland – IMR author), and by the Chair with AD (half brother of GA)

2.19 Following the conclusion of the court case, family and friends of GA were contacted to explain the purpose of the DHR and asked whether they would assist the Review Panel. Only one accepted that invitation, that being GA's half brother, who willingly provided some background information, through a personal interview with the Review Panel Chair.

2.20 At all times, the Panel was sensitive to the needs of GA's daughter, aged 9, as she was not of age to consent to the release of material relating to her education and health records. In compiling this report, the Panel recognises that as she matures, she may wish to have access to the report.

2.21 GA's family and friends have been contacted following the completion of this report and provided with an opportunity to contribute their comments on any actual or potential criticisms in the draft report as it concerns them. No comments were received.

2.22 The Panel discussed whether DH should be interviewed in prison, as part of the DHR process, with the aim of trying to establish whether he could identify any interventions which might have helped prevent him from becoming violent. After considerable discussion by the Panel, it was felt that an interview with DH would be of no benefit to the review process. . It was further felt that an interview would only be of benefit to him and his own self interest and his ultimate hope of being released. DH showed no remorse throughout legal proceedings and it was considered that GA's family would be distressed if the review contained his views/comments.

3. The Facts

GA's Details

3.1 At the time of her death, GA was a 39 year old single mother, who lived with her daughter MA, aged 9 years, in Buckhurst Hill, Essex. She had separated from her husband, AM, in 2009 and met DH in April 2012. Statements from friends and colleagues describe an intense relationship which developed over a short period of time between April and July 2012. They initially appeared to get on well but, by early June 2012, their relationship had rapidly begun to deteriorate.

3.2 On Saturday 7 July 2012, GA and DH went out separately in the Loughton area, but ended up together later in the evening. They went back to DH's Loughton address, where he rented a room. At 4.34am the next morning, GA received a text message from a man she had met in April 2012 but had not seen since. DH apparently saw the text but believed it had come from GA's personal trainer, who he thought she was seeing behind his back. This was the catalyst for the argument which ended with DH stabbing GA in the back and chest.

3.3 At the time of the attack, GA made a mobile phone call to a female friend. The call was diverted to voicemail but was retrieved by the investigating team. The voicemail message recorded the last moments of DH's attack on GA, during which he can be heard tormenting her.

3.4 At 6.36am on 8 July 2012, Essex Police received an emergency call. Police officers attended the address, where they found GA's body. The Essex Ambulance Service attended the scene and GA was pronounced dead. DH was located near to the scene and, following a violent struggle, was arrested on suspicion of murder.

Background Information on GA Prior to her Involvement with DH

3.5 GA was of Scottish decent and was born in ayrshire kilmarnock. Her parents separated and her father moved to Australia, where he has other children. When she was 18 or 19 years of age, GA moved to the Loughton and Buckhurst Hill area to live with her then fiancé. GA made friendships in the local area and found employment in a shoe shop in Wanstead. GA met her first husband AM, when he was a customer at the shoe shop. They married on in 2000 and GA gave birth to their daughter MA in September 2002. The couple separated in May 2009, when GA and her daughter were living at an address in Buckhurst Hill.

3.6 There is no record of police involvement with GA and AM, other than GA committing a speeding offence in 2006, until on 19 January 2010 GA made a telephone call to Essex Police. She was at their home address and she reported that her estranged husband (AM) was present at her home and presenting intimidating behaviour. She called again 7 minutes later to say that AM was now outside the home, sitting in his vehicle. Staff within the police force checked that there were no previous calls relating to domestic incidents at the address and there was no intelligence held in relation to AM.

3.7 Officers attended and spoke to both parties. They identified that there had been a verbal argument and neither party had been assaulted or injured. A Domestic Violence Incident Report Form (DV/1) was completed and risk assessed as 'medium'. Details of this incident were entered on to the PROTECT database. The DV/1 recorded the fact that the couple's daughter MA was present at the premises and that GA was pregnant with her new partner's child, which generated an automatic notification to Social Services. The DV/1 was signed off by a Domestic Abuse Safeguarding Team (DAST) supervisor as medium risk and therefore no other agency referrals were made.

3.8 A further incident took place on 28 May 2010, when GA made a 999 call to the Police. She reported that she had just had an altercation with her estranged husband AM. She informed officers that her husband was under great stress due to the financial implications of their divorce and that his mother was suffering with lung cancer. GA stated that whilst parked in Buckhurst Hill, AM had tried

to get her out of the car by putting his hand under her arm and pulling her up. He was then alleged to have pulled her mobile telephone away as she was calling the police. He then snatched her car keys from the ignition and walked away, throwing them before leaving the scene. The keys were recovered by GA. She informed officers that no children were present at the incident.

3.9 Police officers attended GA's home and completed a DV/1. Although GA did not wish to formally report any crime, a witness statement was obtained from her in respect of a possible offence of common assault. The incident was risk assessed as 'standard' and was signed off by a supervisor. She was given advice regarding home security.

Background Information on DH Prior to his Relationship with GA

3.10 The majority of information detailing the background of DH for the purposes of this review was provided by Norfolk Police and Norfolk and Suffolk Probation Trust (NSPT). There are disparities between Norfolk and Essex Police Criminal Records and the records obtained by Essex Police from the Norfolk Police refer to the following convictions:

16 June 1999**:** Convictions for common assault and intentional harassment

14 June 2002**:** Convictions for wounding (causing a victim a broken jaw) and escaping from lawful custody, leading to detention in Young Offenders Institution. This is where NSPT indicate their first contact with DH. He received a 5 months Young Offender Custodial sentence, plus one month consecutive for the matter of escape. He was released on Home Detention Curfew (HDC) on 24 July 2002 and supervised on licence by an Offender Manager (OM1) until 13 December 2002. No paper file exists and NSPT were unable to review any reports written at this time. At this stage DH was assessed as presenting Medium Risk of harm to others (which means there are identifiable indicators of serious risk of harm). Mention is made in the supervision record that DH recognised that he needed to "adopt controlled drinking techniques" to minimise the chances of further violent offences.

3 December 2003**:** Conviction for wounding with intent to cause grievous bodily harm – a public house 'glassing' leading to 9 months imprisonment.

28 January 2011**:** Conviction for offences of criminal damage and using threatening, abusive or insulting words, committed in November 2010. This resulted in a Community Order, costs of £85.00, compensation of £72.21, unpaid work of 180 hours and an Exclusion Requirement not to enter specified premises. NSPT were not involved in the sentencing process. DH was seen after Court and an induction appointment was given to him; however the case was transferred to Essex Probation Trust on 8 February 2011, only 11 days after sentencing.

3.11 The IMR completed by DH's GP Practice Surgery identifies that on 18 October 2011, DH disclosed that he might have had malaria in the past while working in Africa. On 5 December 2011, DH reported that he had recently returned from Tunisia working on oil rigs. Periods of working abroad may account for the large gaps in allegations and offences between 2003 and 2010.

3.12 On 10 July 2010, DH first came to the attention of Essex Police when they received a telephone call from a woman (BJ) reporting that her former partner had made what she considered to be harassing telephone calls. She had gone to collect her belongings from the property she had shared with DH, taking with her two male friends for protection. They were not present when he later telephoned her.

3.13 Police officers attended the woman's home, where a DV/1 form and a witness statement were completed. The incident was risk assessed as medium and signed off by a supervisor. The Police had intended to serve a first stage harassment warning on DH, but the victim told officers that she did not want them to do this as, on her parents' advice, she did not want to antagonise DH in any way. The DV/1 was passed to the DAST, who contacted the victim and gave her advice regarding home security. She had already made contact with a domestic abuse support project.

3.14 Records disclosed by both Norfolk and Essex Police show a large number of other past allegations dating back to 1999 based on alleged violence by DH, none of which led to convictions. The reports indicate that DH was a person who instilled fear in the complainants. There are a number of allegations of assaults and serious crimes that were not progressed because the complainants were uncooperative by either not making statements of complaint, or withdrawing allegations already made. This is indicated in a number of reports where complainants stated he would harm them further if they assisted in the investigation. It is noteworthy that Essex Police would not have been aware of this information prior to the murder.

Background Information on the Relationship Between GA and DH

Domestic Violence Incident 10 June 2012 - Involvement of Dumfries and Galloway Constabulary

3.15 On Sunday 10 June 2012, Dumfries and Galloway Constabulary (now part of Police Scotland) received a call from an off-duty police officer, reporting what appeared to be a domestic abuse incident taking place within the grounds of a local caravan site. This involved DH, GA and her daughter. GA had asked the informant to call the police.

3.16 The off-duty officer, on hearing a loud bang, looked out of the window of his caravan and observed GA and MA walking towards a Mercedes car. The officer observed that the car had a large dent in the rear offside door that he had not noticed before. (In his statement, he said the car had been parked there for the last day or so). GA got in the driver's side and MA in the rear of the car. The officer heard DH shouting for his mobile phone and he then leaned into the car where GA was sitting. The off-duty police officer came out of his caravan and shouted 'hoi'. DH then stood next to the car, still calling for his mobile phone. GA threw something out of the car. She asked the off-duty officer to telephone the police as DH had just damaged her car. DH picked up the thrown item and GA drove off.

3.17 GA returned and the off-duty officer informed her that the police were on their way. She volunteered the information that they were from the London area and that DH worked on the oil rigs. They were due to return home that evening but she had decided to stay a further night.

3.18 Police officers arrived at the caravan park before GA and MA returned. When she approached them, Acting Sgt G and PC McK observed that GA was upset but had no visible injuries. GA advised that her partner had left the area. She was unaware of his whereabouts and refused to provide details regarding the argument. She spoke of not wanting him back but also of not wanting any involvement of the police. PC McK said that the only other comment made during the conversation was made by MA who said she did not like her mum's boyfriend (DH) and that he was nasty and scared her. The officer commented that he found GA extremely evasive regarding the whole matter.

3.19 The officers conducted a full search of the site and surrounding area but were unable to find DH. They returned to the site and spoke again to GA, who was still unwilling to make a statement or give any further details about the incident. GA was advised by Acting Sgt G of the systems in place to help people suffering domestic abuse and their protocols. GA was left with a domestic violence leaflet.

3.20 Before leaving the caravan site police attended the main reception, where they requested that caravan park staff contact the police if there were any further incidents and to let them know when the couple left the caravan park. PC McK later carried out a check of the Police National Computer (PNC) which revealed DH's date of birth and he was also provided with information that DH had warning signals for weapons and being violent.

3.21 The officers who attended the incident on 10 June were alerted by the caravan site on June 11 that GA, DH and MA had left the site and took the opportunity to stop the vehicle in which they

were travelling. They again spoke to GA, who was still adamant that she did not want to make a complaint. DH was spoken to and he denied any knowledge of the incident.

3.22 A Vulnerable Person's Report (VPR) and SPECCSSS (risk assessment tool used by Dumfries and Galloway police) were completed and emailed to Essex Police on 11 June. The Panel were concerned that these forms were completed after the incident by an officer who had not attended the original incident. The completing officer commented that the attending officers thought the victim was afraid to make a complaint; she also noted that GA and DH were still in a relationship and had no intention of separating. These comments were added after speaking with the officers involved in attending the incident. The SPECCSSS assessment form did not take into account DH's previous convictions as they were not noted from PNC prior to submission of the report. The admin member of staff who carried out the PNC checks was unable to offer any explanation as to why the checks did not reveal DH's warning signals for weapons and being violent.

3.23 The statements from GA's friends and colleagues received by the Panel on 23 July 2013 provided information on a number of incidents which are not recorded in any of the other evidence received by the Panel. These included:

22 May - 9 June 2012**:** DH was working on oil rigs during this period (as advised by Derrick Services Ltd)

2 - 3 June 2012: GA and daughter spent the weekend at a caravan with EK and her family

10 June**:**

03.12am:	Texts sent to EK purporting to be from GA around 'caravan ting'.
06.50am:	Further text
11.00am:	Call from GA to advise the texts were not sent by her
Early afternoon:	Further call asking for confirmation around who had been at the caravan. A male voice was heard in the background
13.09pm:	Dumfries and Galloway Police called to incident at caravan park (as set out in paragraphs 2.15 – 2.22)
Later the same day:	Phone call to EK say that DH had 'kicked off'

13 June – 21 June 2012**:** DH was working on oil rigs during this period (as advised by his Employer)

Thursday 21 June**:** EK discloses that GA advised her that DH had held a knife to her throat and tried to strangle her so that she couldn't breathe. GA disclosed that her daughter was in the property at the time, upstairs in bed, and that DH had punched the fridge and made a dent in the door.

Friday 22 June**:** GA and DH argued whilst driving to the tattooist. While DH was in the shop, GA ran out and drove away. GA disclosed that she was terrified and did not want to return home. GA advised that she would be staying at KW's home.

Saturday 23 June, 06.30am**:** DH went to KW's home and was only persuaded to leave after getting hold of GA's phone and sending a text. At some point during these events GA collected her daughter (MA) and, together with KW, decided to stay at the Marriot Hotel, Waltham Abbey rather than return to her home address. While they were staying at the hotel, DH made threats to "burn her house down"' with GA and MA inside and also threatened to slash KW's face if she reported any incidents to the police.

4 July: GA and DH were at a restaurant when GA received a text from an ex-boyfriend. DH read the text and "went mad ". He took GA's phone, removed the SIM and would not return them. The argument continued outside the restaurant where GA got into a taxi. The taxi driver intervened asking should he call the police and GA threatened to call the police herself. However, DH gave back the phone and SIM and GA went home without contacting the police.

5 July**:** DH contacted his employer to advise that his partner had hidden his Personal Protective Equipment (PPE) and he was unable to go to work.

GA visited Tuscany Restaurant in Loughton High Street with family and friends. She disclosed that she wanted to move as she did not feel safe. Later that evening, she visited five licensed premises in Loughton with KW; DH turned up at every one of the bars.

6 July**:** DH sent a text to GA, threatening to take tablets.

7 July**:** GA & KW visited Bar 15 where they met DH. They left these premises and moved to the NuBar, where they were later joined by DH and a friend.

8 July: At 01.00am KW left GA and DH together and returned home. KW received two calls from GA at 03.00am and 05.15am, which she did not answer. At 08.30am, KW received a phone call to advise that GA had been killed.

3.24 During the period 23 June to 4 July, there may have been further incidents but the Panel was unable to identify any specific dates from the statements of friends and work colleagues. Information from DH's employer indicated that he was not employed during this period and he was therefore likely to have remained in the local area.

3.25 The statements from friends and colleagues paint a picture of an intense relationship which developed over a short period of time between April and July 2012. Initially GA and DH appeared to have seen each other nearly every day and GA talked about a permanent relationship, with the possibility of marriage and a baby. Friends described her as being very happy. DH returned to work on the oil rigs but on his subsequent return to the local area, the relationship rapidly began to deteriorate. GA commented to her friends that she needed the space when he was away, as he was so intense.

3.26 The statements illustrated that DH presented all the classic signs of a serious abuser. These included:

- The intensity of the relationship
- Distrust and jealousy (checking the phone, removal of SIM card and sending texts purporting to be from GA to her ex-boyfriend)
- Attempts to control by removing SIM – restricting access to phone and friends
- Stalking by using mobile phone and following GA around clubs
- Threats and use of physical force (damage to car and fridge)
- Disclosure of strangulation and threat with knife (which would eventually be the homicide modus operandi)
- Threats to friends (KW)
- Threats to property (arson threat to GA and daughter)
- The intense escalation from domestic harmony to fear over a short period of time

3.27 GA disclosed to her friend EK that DH had started texting her. He would start saying nice things but when she would not agree to do what he wanted he would turn nasty and call her names like 'slut'. She told EK that she was frightened of him and was worried that he was watching the house. She would not hear anything for a day or two but then he would start texting and phoning, sometimes until the early hours of the morning. GA disclosed to EK that DH "needed help for his anger. He said that he would get help if she got back with him".

3.28 GA disclosed to her friend AF that "DH was really insecure and had loads of issues because he had been abused when he was a child. This meant he was very intense being in a relationship with him. I felt it was a good job he worked away as she probably did not need that 24/7".

3.29 The Panel can find no evidence in the information provided as to whether any friends or colleagues urged GA to contact the police or support agencies as DH's behaviour escalated. However some of her friends were threatened by DH themselves and others have spoken about

being frightened about what he might do and this may have prevented them from contacting the Police or a domestic abuse agency.

3.30 Because GA's friends and colleagues declined the invitation to engage with the review, the Panel was unable to ascertain whether they were aware of local support agencies or refuge provision. However, GA's half brother believed that they would have been aware as these services were well advertised locally or easy to access on the internet.

Legal process

3.32 The Panel did not have access to the post mortem results or the outcome of the Inquest. The trial of DH took place at Chelmsford Crown Court on 15 February 2013, where he pleaded guilty to murder and was sentenced to life in prison with a recommendation that he serve a minimum of 17 years and 6 months before release.

Sentencing Remarks

3.33 Judge Gratwicke described the murder as "a brutal, vicious and senseless attack caused, it is clear, by DH's jealousy and rage arising out of the mistaken belief that GA was being unfaithful to you with her gym instructor. In rage you took that knife and plunged it into her with significant force as the medical evidence makes clear as she fought to keep you away, as the scratch marks to her hands indicate".

3.34 Judge Gratwicke described DH as a "violent man. This was not the first occasion you threatened her. You previously held a knife to her throat. She tragically remained with you in the relationship with devastating consequences."

3.35 Judge Gratwicke imposed a sentence of life imprisonment. He found it an aggravating feature that DH used a knife – "You went to the kitchen and got it.". He also noted that DH moved GA's body and placed the knife in her hand in an attempt to suggest that GA had initially attacked him. The Judge commented that after listening to the tape and having reminded himself of what DH was heard to shout out that night, he was satisfied that DH did intend to kill her once she had received the text.

4. Key Events Analysis

4.1 Developing the DHR provided an opportunity to analyse information across agencies and family members, colleagues and friends of the victim. There is a danger, in reviewing situations with hindsight, that conclusions are formed that were not possible for the participants to see at the time. During the last four weeks of GA's life, there were indicators that DH's behaviour was escalating and becoming increasingly dangerous and threatening towards her. During this period, GA disclosed a number of incidents separately to various friends and colleagues.

4.2 The only incident between GA and DH which was reported to police took place in Scotland on 10 June 2012 and was dealt with by Dumfries and Galloway Police. This was at the beginning of the period during which DH's violent behaviour escalated. GA asked an off duty police officer to call the police on her behalf following a domestic abuse incident which had taken place at the caravan park where she and DH were staying. Police attended, carried out a search and found that DH had left the area. GA was visibly upset but did not want to provide details of the incident or have any involvement with the police. MA was present at the incident and reported to one of the officers that DH was "nasty and he scared her ". The attending officers provided GA with the contact number for local police and details of support services for victims of domestic abuse.

4.3 A PNC check carried out by an administrative staff member of Dumfries and Galloway Police failed to identify that DH had an extensive criminal history and this was therefore not a factor considered when the VPR and SPECCSSS risk assessment form were completed. Although the comments made by MA about DH were noted in the statements of the officers who attended the

incident, the VPR does not record that MA was spoken to. Also, the SPECCSSS form recorded that it was "the opinion of the attending Police officers that the victim was afraid to make a complaint" and was "frightened of further injury or violence". The Panel noted that the SPECCSSS form indicated that a Child Concern Form had been completed; however, no evidence of this was provided to the Panel. Despite all these factors, the incident was assessed as having a 'standard' level of risk.

4.4 The officers who attended the incident on 10 June asked the owners of the caravan park to alert them when DH, GA and her daughter left the site and on 11 June, took the opportunity to stop the vehicle in which they were travelling. They again spoke to GA, who was still adamant that she did not want to make a complaint. DH was spoken to and he denied any knowledge of the incident. Although GA and DH were spoken to separately, the Panel felt that it may have been difficult for GA to engage with the police with DH present.

4.5 The Panel was informed that procedures for dealing with domestic abuse incidents in Scotland have been reviewed since the incident, following the creation of the national Police Scotland force.

4.6 On the day after the incident at the caravan park (11 June), Dumfries and Galloway Police emailed the VPR and SPECCSSS form to Essex Police. Unfortunately the e-mail was deleted without being opened, and Essex Police have been unable to identify who was responsible. At that time, Essex Police procedures for dealing with reports of out of force incidents with a risk assessment of 'standard' only required that the incident be entered on the PROTECT database. Staff were not required to complete either PNC or intelligence checks. Therefore, even if the email had been opened, it is unlikely that Essex Police would have contacted GA on the basis of the information supplied by Dumfries and Galloway Police.

4.7 The Panel was advised that Essex Police procedures for dealing with reports of out of force incidents have now changed. Under the new procedures, when a report of an out of force incident is received, Essex Police carry out background checks on the victim and perpetrator. If the checks reveal information which is of concern, the incident may be allocated a higher risk level and relevant action taken. Even if these procedures had been in place at the time of the report from Dumfries and Galloway Police, it is likely that Essex Police would have retained the 'standard' grading of the incident, as there were no previous known incidents of domestic abuse between GA and DH.

4.8 In dealing with the information obtained from the incident in Scotland, both Dumfries and Galloway and Essex Police did not fully implement procedures which were in place at the time and some procedures were not sufficiently robust to flag up concerns. However, the Panel was of the opinion that this did not have a bearing on the ultimate outcome of the case and that GA's murder could not have been foreseen on the basis of the information available to both forces Since the incident, both Essex Police and Police Scotland have reviewed their procedures for dealing with domestic abuse incidents.

4.9 Following the incident in Scotland, DH was working away on the oil rigs during the period 13 – 21 June 2012. On his return, the incident disclosed by friends, where he attempted to strangle GA and damaged her fridge, took place. On 23 June, it is reported that DH made a further threat to burn down GA's house with her and MA inside. A statement made by GA's friend KW indicated that she received a threatening phone call from DH. She told him that she would contact the police if he called her again and he replied "do that and I'll slash your face". Despite the threat of violence, KW did not report her concerns to the police, although she and GA were both sufficiently scared to stay in a local hotel rather than return to their homes.

4.10 On 4 July a further incident occurred which could have offered an opportunity for GA to engage with the police. GA and DH were at a restaurant when GA received a text from an ex-boyfriend. DH read the text and "went mad ". He took GA's phone, removed the SIM and would not return them. The argument continued outside the restaurant where GA got into a taxi. The taxi driver intervened asking if he should he call the police and GA threatened to call the police herself.

However, DH gave back the phone and SIM and GA went home without contacting the police. In her statement LB, who was babysitting for GA, noted that GA was sufficiently scared to ask her to stay with her that night but LB was too scared herself to stay, as the picture GA had painted of DH made her "scared of him, he gave me the creeps".

4.11 In the weeks before her murder, GA expressed to friends and some family members that she wanted to end her relationship with DH. At that point she felt she could handle the situation and AD reported that she wanted to "do this the right way" in order to prevent "setting him off". It was not until the last two weeks of the relationship that GA expressed concerns about her safety and, even then, from the evidence available, the Panel could not be certain that she fully appreciated the extent of the danger that she was in. Although GA was clearly scared of DH, she does not appear to have actively considered measures to avoid him and continued to go with friends to the same pubs and clubs which he frequented. As neither GA, nor the friends and colleagues who were individually aware of some of DH's abusive behaviour, reported the situation to any agency, there was no possibility of intervention which might have changed the eventual outcome of this case.

4.12 The statements from GA's friends revealed that MA was present at a number of the incidents prior to the murder and the Panel considered how this may have impacted on her welfare. Although there is no way of ascertaining, the question arose as to whether MA made her concerns about DH known to her father or grandparents. She was present at a number of incidents and must have been aware of the texts and phone calls and listened to her mother's conversations with friends and her grandmother. We do not know whether MA woke up on the night of the attempted strangulation or how she interpreted the fact that, because her mother did not feel it was safe to go home, they spent a night at the home of her mother's friend and the subsequent night in a hotel.

4.13 If Dumfries & Galloway police officers had completed a Child Concern Form and Essex Police had opened and dealt with the e-mail, the form would have generated an automatic notification from Essex Police to Essex Children's Social Care Incident Response Team (IRT) advising them that an incident had occurred and a child was present. The IRT would then have conducted a threshold test to decide if any action was required. .

4.14 If GA's friends, colleagues or family had been aware of the full extent of DH's violence towards her and the manner in which it escalated over a very short timeframe, they might have considered reporting their concerns to the police or a domestic abuse agency. However, the Panel considered that there is no obvious mechanism for third parties to report such concerns without the victim's consent or knowledge. In this situation, friends and colleagues would have been faced with the dilemma that, in reporting her situation, they would be breaking GA's confidence. GA's friends may have also felt scared and intimidated themselves by DH's behaviour and this may have been a reason for them not contacting police or other support agencies.

4.15 The Panel believes that GA's case illustrates the need for the development of channels to enable third parties to report domestic abuse in confidence. This would not happen quickly: a new reporting infrastructure would have to be put in place and changes to social attitudes needed. Information would need to be made widely available to help people understand that such reporting can help a victim take control of their situation and could save their life and that this is more important than keeping a confidence. Within these reporting structures there would also need to be safeguarding measures to protect family and friends reporting domestic abuse, as often they are in fear of retaliation from the perpetrator.

Timeline of Key Events Leading Up to the Murder

DH

16 June 1999: Common assault and harassment – conditional discharge and compensation order

14 June 2002: Wounding (causing victim a broken jaw) – 5 months detention in Young Offenders Institution and Escaping from Lawful Custody – 1 further month's detention

3 December 2003: Wounding with Intent to Cause Grievous Bodily Harm (public house glassing) – 9 months imprisonment

10 July 2010: Medium risk domestic abuse incident between DH and BJ – verbal argument via telephone. Police attended – statement and DV/1 completed. Police requested not to contact DH by victim's family.

28 January 2011: Criminal Damage and Using Threatening, Abusive or Insulting words – Community Order with 180 hours of unpaid work to be undertaken.

7 February 2011: Moved to Essex

5 January 2012: Appeared at North Essex Magistrates Court and convicted of failing to comply with the requirements of the Community Order – additional 10 hours unpaid work to be undertaken

8 February 2012: Transferred from Norfolk and Suffolk Probation Trust to Essex Probation Trust

20 April 2012: Appeared before West Essex magistrates Court for breach of Community Order – Court revoked the Community Order as unworkable and substituted a £100 fine.

GA

16 January 2010: Domestic abuse incident between GA and estranged husband (AM). Police attended a verbal argument concerning child access/contact. DV/1 completed and risk assessed as medium.

28 May 2010: domestic abuse incident between GA and AM. Police attended and DV/1 completed. Crime report completed for assault with no injury.

April 2012: GA and DH meet for the first time at Royal Oak public house, Loughton.

April – June 2012: DH working on oil rigs – frequently absent

2 – 3 June 2012: GA and daughter spent the weekend at a caravan with friends (EK)

22 May to 9 June: DH working on oil rigs

10 June 2012:

03:12am:	Text sent to EK purporting to come from GA about 'caravan ting'.
06:50am:	EK replies to text
11:00am:	EK received phone call from GA saying that text had been sent by DH
Early afternoon:	Further call from GA to EK asking for confirmation of who had been at the caravan. Male voice was heard in the background.
13:09pm:	DA incident between DH & GA in caravan park in Scotland . Victim and perpetrator were observed by an off duty police officer to be involved in a verbal altercation. GA asked the off duty officer to contact the police which he did. D & G Police attended who were advised by GA she had been involved in a minor argument and refused to make any complaints or provide a statement to Police ~SPECCSSS and Vulnerable Persons Report completed
Later in day:	Further phone call from GA to EK saying that DH had 'kicked off'.

11 June 2012: GA & DH stopped on A74 by the same D & G officers who attended the caravan park incident.
Dumfries and Galloway Police email out of force information on the caravan park incident to Essex Police. Email is deleted on receipt and no action taken.

13 – 21 June: DH working on oil rigs

21 June: EK discloses that GA advised her that DH had held a knife to her throat and tried to strangle her so that she couldn't breathe. GA disclosed her daughter was in the property at the time, upstairs in bed and that DH had punched the fridge and made a dent in the door.

22 June: GA and DH visited the tattooist. Whilst DH was in the shop, GA ran and drove to KW' s home. GA disclosed that she was terrified and did not want to return home. GA advised she would be staying with KW

23 June 06.30am: DH went to KW's home and was only persuaded to leave after getting hold of GA's phone and sending a text. At some point during these events GH collected her daughter and both she and KW decided to stay at the Marriot Hotel in Waltham Abbey, rather than return to her home address. Whilst they were at the hotel DH made threats to 'burn her house down' with GA and MA inside and also threatened to slash KW's face if she reported any incidents to the Police.

4 July: Incident at Sheesh restaurant. GA and DH argued in the restaurant taxi driver intervened and offered to call the police

5 July: DH advised his employer that he could not go to work as his partner had hidden his personal protective equipment
GA, family and friend visit Tuscany Restaurant in Loughton High Street where GA disclosed she wanted to move as she didn't feel safe.
Later on, GA visited five licensed premises in Loughton with KW. DH turned up at each one.

6 July: DH sent text GA threatening to take tablets

7 July: GA & DH meet at Bar15 and NuBar, Loughton

8 July: In the early hours of the morning, DH murdered GA, following an argument over a text message.

5. Lessons Learnt

Lesson Learnt - Individual Agencies

Dumfries and Galloway Constabulary (now Police Scotland)

5.1 The review identified that there was a need to ensure that accurate checks of all databases are carried out to allow the reporting officer to make an accurate assessment prior to sending reports to partner agencies. The Panel was advised that V Division, Police Scotland are in the process of migrating to a new Vulnerable Person Database which will include a new domestic abuse form. This form will include a 27 DA question set which the attending officers at an incident will complete with the victim. These questions are based on the DASH 2009 risk assessment tool and include a 'don't know' response as well as the 'yes' and 'no' options. The 'go live' date for this system was 9 September 2013. The new system allows for the attending officers to assess the risk to the victim dependent on the answers to the 27 question set. A further risk assessment will be completed by Domestic Abuse Unit staff on receipt of the form, taking into account all information, current and previous, in relation to the victim and perpetrator.

5.2 The review also identified a need for procedures to ensure that reports of out of force incidents are received and acknowledged by the other force. Police Scotland procedures are now that when such an incident occurs, the domestic abuse form will be e-mailed (receipted) to the appropriate Force with a telephone contact to advise that it is being sent. A receipt will be requested and the chronology updated to that effect on the Police Scotland database.

East of England Ambulance Service

5.3 Their IMR identified that ambulance services do not collate information through names, merely addresses or places where the public become unwell or injured. This means that there may be cases where they have treated the services users in this review in other locations or public places that have not been considered by this review

Essex Police

5.4 Gaps in procedures for dealing with reports of out of force incidents were identified. New procedures have been introduced to ensure that when a report of an out of force incident is received, Essex Police carry out background checks on the victim and perpetrator. If the checks reveal information which is of concern, the incident may be allocated a higher risk level and relevant action taken.

5.5 The Panel recognised that it would have been extremely informative for a member of the police investigating team to attend a meeting after the legal proceedings had been completed, as it was often difficult to know what information to ask for when the Panel did not know what was available. An example of this was the disclosure of a previously unknown incident between GA and DH in the sentencing remarks made by Judge Gratwicke. This came towards the end of the process of the review and when the Panel asked for further information regarding this incident, copies of statements from friends and colleagues of the victim were provided. This information was of great benefit to the Panel and clearly demonstrated how the relationship between GA and DH rapidly deteriorated. Without this information, the Panel would have been unaware of the extent of the abuse GA was suffering in the last few weeks of her life.

Essex Probation Trust

5.6 This review has highlighted issues around the management of risk; in particular, the assessment of low-risk offenders and ensuring that this is a robust and accurate process. The pre-sentence work in relation to DH was undertaken by Norfolk and Suffolk Probation Trust. In Essex, as a minimum, a risk of harm screening and Offender Group Reconviction Scale (OGRS – risk assessment tool) calculation is completed at Court. The OGRS is also used to determine eligibility

for some interventions, notably accredited programmes. Reports are written on offenders who evidence a risk of harm. Post-sentence, these cases would always be allocated to an Offender Manager.

5.7 In this case, DH may not have had a risk of harm screening undertaken and, more likely, he was assessed as low risk due to the time that had elapsed since his last conviction. Risk of harm screening documents are now completed and retained on the system; there is not a reliance on paper copies. The case was allocated to two Requirement Officers (BP and KW) who were new in post and their role was essentially an administrative one. They accepted the risk of harm allocated to the case and admitted that the previous convictions would not have prompted them to ask for a management review. The fact that the case went to a Requirement Officer meant there was a less investigative approach; the statement about risk contained in the CPS papers was not immediately apparent nor was there a request for background information from Norfolk and Suffolk Probation Trust or Police. As a result, DH slipped through the usual safeguards and was managed as a much more benign offender that he actually was. Had information about domestic abuse come to light, then the case would certainly have been reallocated.

5.8 Essex Probation has ended the practice of allocating Unpaid Work Orders when they have other requirements, to Requirements Officers. Only stand alone Unpaid Work Orders are held by Requirement Officers. KW confirmed that she does not hold any other cases. If DH was a transfer-in case today, he would be allocated an Offender Manager and, at the very least, a Layer 1 Offender Assessment (OASys) would be completed.

5.9 Compliance and enforcement activity was good. If more had been uncovered about DH's risk, then possibly a different proposal could have been made to the court in relation to the breach. As it was, the court was advised of the problem around DH's employment and commitment to complete his order when he was available. There are processes in place to allocate offenders according to risk of serious harm. In this case they failed to guard against the under estimation of risk. The issues identified are internal ones for Essex Probation. This case is not one which provides for an inter-agency approach.

<u>Loughton Health Centre</u>

5.10 Need for Domestic Abuse Policy at the surgery to be addressed as a priority.
(See Action Plan – point 2).

<u>Norfolk and Suffolk Probation Trust (NSPT)</u>

5.11 Practice since 2002 and 2004 has significantly changed both nationally and within NSPT. The quality of the OASys dated 14 January 2004 would not be deemed sufficient by the standards expected today, although the overall assessment of DH's Risk of Serious Harm may well have remained as Medium Risk of Harm.

5.12 In relation to the sentencing exercise in January 2011, the Court Duty Officer would have had access to the aforementioned OASys document but given the time span between that document and DH's next court appearance, the officer would not have relied fully on that document had the Court sought a view from NSPT.

5.13 There is evidence from the electronic records that the transfer of this case took place in a timely way and indeed all hard copy papers were also transferred to Essex Probation Trust as that time. There is a suggestion in the Integrated Case Management System (ICMS) record of the retention of a skeleton record, but discussion with the Operational Support Manager for that office in January 2011 suggests that such a file may have been emptied when the Great Yarmouth office merged with the Lowestoft office in November 2011, if indeed it existed at all. The NSPT Procedure Note to staff in relation to External Transfers does not clearly specify that NSPT requires staff to retain a hard copy skeleton file with essential papers in it, although this is often the practice.

St Johns School, Buckhurst Hill (Schools, Children and Families Directorate, Essex County Council

5.14 The Head teacher is familiar with the Southend, Essex and Thurrock (SET) procedures but acknowledged that through this process a fuller understanding of the impact of domestic abuse would be advantageous. As a school considered outstanding by OFSTED, the head teacher is responsible for the training of new teachers and has committed to ensure that he revisits safeguarding with particular attention to domestic abuse.

Traps Hill Surgery

5.15 The clinical team was briefed informally and made aware that the review was taking place. The issue was raised at a clinical team meeting in December 2012 with regard to awareness but no changes in practice have been identified as there were no red flags apparent in any of the consultations. Administrative staff will be kept up to date with briefings.

6. Conclusions

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The following conclusions have been drawn from the review process:

(1) There was only direct evidence of one recorded incident of domestic abuse between GA and DH in the period leading up to her murder, that being the incident in Dumfries and Galloway on 10 June 2012;

(2) Whilst there is anecdotal evidence via witness statements of friends of GA of the escalating levels of violence and intimidation of GA by DH, it is clear that neither GA nor her friends or family made any formal representations to the police or other agencies;

(3) It was often difficult to know what information to ask for when the Panel did not know what was available.

(4) Whilst it is clear that not all the formal information exchange protocols had been correctly followed in this case by the agencies involved, and had they been, additional steps might have been taken; it appears very unlikely that these additional steps would have resulted in any action which would have prevented the murder taking place; and

(5) GA, despite the increasingly violent and intimidating behaviour of DH, took no steps to engage with the police or other agencies. Whilst this approach may well have been influenced by fear of reprisal by DH, she appeared to be of the view that she was able to manage the situation she was in without fully appreciating the degree of risk she was exposed to. Her view of the situation may have been different had she had more access to information on domestic violence and the resources available to address it.

7. Recommendations

7.1 Individual Agencies

Through the production of their IMRs, a number of agencies identified key areas for review and have made recommendations regarding future actions. These are set out below:

<u>Essex Probation Trust</u>

R1. The findings of Domestic Homicide reviews to be made available to relevant staff across the Trust.

R2. Relevant staff to be instructed to read the case files.

R3. An accurate Risk of Serious Harm to be completed and retained on the case record. This must take into account the offender's previous convictions and other relevant material from the case file.

R4. No violent offender to be assessed as low risk of harm without the endorsement of a manager.

R5. Requirement Officers to only to hold singleton unpaid work orders which are assessed as low risk of harm.

<u>Norfolk and Suffolk Probation Trust</u>

R6. That the NSPT Procedure Note relating to the External Transfer of Cases to be revised to include instructions to staff to retain a skeleton hard copy file in all cases where the matter is transferred to another Trust.

Directorate of Schools, Children and Families, Essex County Council

R7. The Director of Learning to provide briefings and learning opportunities for schools and academies on the outcome of this review with a focus on the school role in identifying domestic abuse, the impact on children and protective factors.

East of England Ambulance Service

R8. Details of service users to be recorded by name and gender in all ambulance attendances

7.2 Recommendations from the Review Panel

The Review Panel considered the recommendations outlined above from some of the agencies who produced IMRs, and endorses them. In addition, the Panel has considered what additional recommendations arise from the review process overall, and these are set out below.

The Review Panel recommends as follows:

The IMR supplied by Loughton Health Centre identified that the practice was not aware of any previous domestic abuse issues and the perpetrator did not disclose any issues. Accordingly, the practice was unaware of any wider concerns that may have been relevant to the treatment and referral decisions made. It is therefore recommended:

R9. that all agencies share domestic violence reports with both the victim's and the suspected perpetrator's GP.

The IMR supplied by the Traps Hill Surgery identified a training need for their medical and administrative staff and the review panel felt that this could reflect a wider training requirement. It is therefore recommended:

R10. that all GP practices undertake a review of the training provided to their medical and administrative staff.

Further general recommendations of the review panel

R11 A common system be developed for all relevant agencies to allow third party reporting of domestic abuse.

R12 Immediate action be taken to improve safeguarding training relating to domestic abuse in schools and colleges

R13 That the practice of co-locating of police, domestic abuse, child abuse, and adult abuse staff with professionals from Children's Services, Advocacy, Health and Probation in the Multi-Agency Safeguarding Hub (as is the practice with the Norfolk Constabulary) be considered for adoption countrywide.

R14. A member of the police investigating team to attend a review panel meeting at the earliest opportunity after the legal proceedings had been completed.

The action plan set out as appendix B is intended to take the above recommendations forward.

8. Chair's Remarks

8.1 The attendance of members of the Review Panel was exemplary as was their commitment to its task. Given the number of police forces, probation trusts as well as health trusts and doctors surgeries involved, it was a complex jigsaw to complete, sometimes hampered by delays in receiving the IMR reviews and then awaiting responses to further questions. However, the additional information was invaluable to the task and also revealed that procedures had already been changed in relation to earlier incidents or changed following the investigation.

8.2 West Essex Clinical Commissioning Group and in particular, Shona Siewerstsen, was especially helpful in assisting GA's and DH's GP surgeries to complete their IMRs. This has led to recognition of the need for domestic abuse training for GPs, which has already been introduced, as well as an acknowledgement that all practice staff, including receptionists, need to be aware of domestic abuse issues.

8.3 The Panel was grateful for the intervention of Catherine Adams of Essex County Council's Schools, Children and Families Directorate who, on behalf of the Panel, worked with MA's school to complete their IMR, after they originally declined to complete one.

8.4 The willingness of the IMR author from Dumfries and Galloway police force to attend the Panel meeting was of great benefit and there was learning for both police forces. As the Chair, I felt that the culture of enquiry rather than blame, exercised by the Panel members, enabled the learning to take place. To have a retired Judge as a Panel member was particularly helpful in regard to the legal process and details of court documents.

8.5 A major difficulty we experienced was the delay in receiving the IMR from Essex Police, and it is not clear what caused the delay, as there was a significant period between the original request for the IMR and its receipt.

8.6 We were also requested by Essex Police, and in accordance with the guidance available at the time, not to contact family and friends until after the trial. However, on receipt of Home Office provided training after the court hearing, it was noted that there was a recommendation that, at the beginning of the process of a DHR, the Chair should contact the family and friends and introduce themselves and explain the DHR process, with the caveat that they would not be speaking to them until the court case was concluded. It was also recommended that the Chair attend the final stages of the trial. Unfortunately, this training came too late for this particular DHR.

8.7 In order to ensure that the learning from this DHR is disseminated across Essex, the Safer Communities Manager represents the District at the countywide Domestic Homicide Review Group and feeds in recommendations and learning and advises the Panel of recommendations from other DHRs ongoing in the county.

8.9 It would have been of benefit for an investigating officer to attend a review meeting so that the Panel could reassure themselves that the family had, or were able to access, any support services they required.

8. Appendices

Appendix A: Participation in the Review

Appendix B: Action Plan

APPENDIX A

Participation in the Review

1. Agencies which were contacted as part of the initial scoping exercise were:

Anglian Community Enterprises
Basildon and Thurrock University Hospitals NHS Foundation Trust
Basildon Borough Council
Braintree District Council
Brentwood District Council
CAFCASS (Child and Family Court Advisory Service)
Castle Point District Council
Central Essex Community Services
Chelmsford Borough Council
Colchester Borough Council
Colchester Hospital University NHS Foundation Trust
Derrick Services Ltd (employer of DH)
Dumfries and Galloway Constabulary
East of England Ambulance Service NHS Foundation Trust
Epping Forest District Council: Council Tax
Electoral Registration
Community Development
Essex County Council: Schools, Children and Families Directorate
Adult Health and Community Wellbeing
Drugs and Alcohol Team
Safeguarding Children Board
Youth Offending Service
Essex Police
Essex Probation Trust
Essex Women's Aid / Safer Places
Great Yarmouth Borough Council
Harlow District Council
Harlow College
HMPs Norwich, Wayland and Bure CARAT (Counselling, Assessment, Referral, Advice and Drug Rehabilitation Programmes and External Drugs Intervention) Teams
Leeway (Independent Domestic Violence Advisors)
Loughton Health Centre
Maldon District Council
Matthew Project (Drug and Alcohol Support, Norfolk and Suffolk)
Mid Essex Hospital Services NHS Trust
NHS South Essex
NHS North Essex
Norfolk and Norwich University Hospitals
Norfolk Constabulary: Vulnerable Persons Directorate
DAAT Strategy Manager
Community Safety
Domestic Abuse Reduction Co-ordinator
Norfolk County Council: Children's Services
Safeguarding Adults
Safeguarding Education & Health
Safeguarding Mental Health
Fire and Rescue Service
Norfolk & Suffolk Probation Trust
North East London NHS Foundation Trust
North Essex Partnership NHS Foundation Trust

Norwich City Council
Orwell Housing (IDVA Service)
Princess Alexandra Hospital NHS Trust, Harlow
Rochford District Council
Southend-on-Sea Borough Council
Southend University Hospital NHS Trust
South Essex Partnership University NHS Foundation Trust
St John's School Buckhurst Hill
Tendring District Council
Thurrock Borough Council
Traps Hill Surgery
Uttlesford District Council
Victim Support: Essex and Hertfordshire
Norfolk

2. Agencies were asked to give chronological accounts of their contact with the family prior to the victim's death. Where was no involvement, or insignificant involvement, agencies advised accordingly. Each agency's report covers the following:

- *A chronology of interaction with the victim and/or their family;*
- *What was done or agreed;*
- *Whether internal procedures were followed; and*
- *Conclusions and recommendations from the agency's point of view.*

3. The accounts of involvement with the victim and perpetrator cover different periods of time prior to the victim's death. Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies.

4. In total, 33 agencies responded as having had no contact with either the victim or the perpetrator or with the victim's daughter.

5. The following twenty-two agencies responded with information indicating some level of involvement with the victim or the perpetrator.

Basildon and Thurrock University Hospitals

Information supplied: Chronology of three attendances at Basildon University Hospital by DH between 20 and 26 October 2009.

Last contact with this agency: Discharged from hospital care on 26 October 2009.

Relevance: DH's contact with Basildon and Thurrock University Hospitals was not relevant to the events that led to the death of GA.

Basildon Borough Council
Information Supplied:

- Council Tax records for an address in Basildon, relating to DH and another female for the period 17 September 2009 – 10 March 2010

- Council Tax records for the same address in Basildon, relating to DH only, for the period 11 March 2010 – 6 July 2010

- Benefit application by DH on 1 June 2010. The claim was not completed and was closed on 26 October 2010.

Last contact with this agency: Closure of benefit claim 26 October 2010.

Relevance: The information supplied enabled the Panel to further investigate details of the female named on the Council Tax records as a potential victim of DH. This was later discovered not to be relevant to the events that led to the death of GA.

Employment agency which placed DH in work

Information Supplied: IMR giving overview of the company's involvement with DH and details of an interview with the Senior Personnel Co-ordinator regarding events between 5 July and 8 July 2012 (the date of the murder).

Date information supplied: 30 November 2012

Last contact with this agency: The Company tried to contact DH on Monday 9 July to offer him work. They were unable to reach him as he was in custody.

Relevance: IMR indicated that:

- DH contacted the agency on 5 July 2012 and advised them that his partner had hidden his personal protective equipment and he was therefore unable to go to work.
- Essex Probation Trust had contacted the agency to enquire about DH's working arrangements but the agency did not then make any enquiries about what offences he had committed. This was of concern to the Panel, as his work on oil rigs meant that he was working with others in a confined area and the agency was unaware of his criminal background. The Panel questioned whether the agency had the right to ask someone who was on probation about the nature of their offences.

Dumfries and Galloway Constabulary

Information Supplied:

- IMR containing a record of an incident involving GA and DH at Auchenlarie Caravan Park, Gatehouse of Fleet on 10 June 2012
- Copies of statements from Police officers who attended the incident
- Copy of the statement of the off duty Police officer who reported the incident
- Copy of SPECCSSS risk assessment form completed after the incident
- Copy of Vulnerable Person's Report completed after the incident
- Briefing note in response to questions raised by the Panel
- Domestic Abuse Joint Protocol between the Association of Chief Police Officers in Scotland and the Crown Office and Procurator Fiscal Service

Dates information supplied:
IMR: 30 November 2012
SPECCSSS form: 12 March 2013
Statements of attending Officers: 21 June 2013
Vulnerable Victims Form: 23 July 2013

Last contact with this agency: 11 June 2012. Officers who had attended the previous day's incident at the caravan park stopped the car in which DH, GA and her daughter were travelling. The officers asked if GA wanted to make a complaint about the incident but she declined.

Relevance:

- The information supplied by Dumfries and Galloway Constabulary provides the only record of a domestic abuse incident involving GA and DH prior to the murder, which was reported to a police force.
- IMR provided a disclosure by MA that 'she did not like her Mum's boyfriend, as he was nasty and made her scared'. However a Child Concern Form was not completed, despite an

indication on the SPECCSSS form that this had been done. The Panel queried whether, if the form had been completed, it would have altered the risk assessment or flagged up concerns to other relevant agencies.

- Format of the SPECCSSS form, which requires questions to be answered 'yes' or 'no' with no provision for the answer to be 'not known'. Many questions were answered with a 'No' when the true answer would have been 'Not Known'. The Panel considered that the current format and the responses wrongly given could give a false impression of low risk.
- Following the incident at the caravan park, the attending officers had submitted a Vulnerable Person's Report to the Family Protection Unit. When checks were carried out, they failed to identify DH's criminal history. Subsequent checks have failed to identify why this happened. It was agreed that, if details of DH's criminal history had been available to the officer carrying out the risk assessment, this would have increased the level of risk allocated.
- The risk assessment was not completed by the officers who attended the incident at the caravan park.
- The Vulnerable Person's Report and risk assessment were emailed to Essex Police but Dumfries and Galloway Police did not telephone to seek confirmation that Essex Police had received the documents.
- If the incident had been assessed as either high or medium risk rather than standard, Dumfries and Galloway Police would have also made a phone call to Essex Police in addition to the email which was sent. This would have alerted Essex Police to the email and would have provided additional background information. There was no request for confirmation of receipt included in the message and procedures have now been changed to always ask for confirmation of receipt of emails in these cases.

East of England Ambulance Service NHS Trust

Information Supplied:

- Initial response to scoping exercise confirming Ambulance Service response to murder
- IMR setting out summary of facts of Ambulance Service attendance at the murder scene

Date information supplied: 27 November 2013

Last contact with this agency: Attendance at the murder scene on 8 July 2012 was the Ambulance Service's only contact with the victim.

Relevance: Not relevant to the events that led to the death of GA. However, the IMR identified that the ambulance services do not collate information through names, merely addresses or places where the public become unwell or injured. This does mean that there may be cases where they have treated the services users in this review in other locations or public places that have not been entered into this review.

Epping Forest District Council: Council Tax

Information Supplied:

- Record of non-payment of Council Tax by GA, including details of a telephone call made by GA to the Council Tax office on 18 June 2012.
- Record of a phone call made by GA's ex-husband (AM) to the Council Tax office on 22 February 2011 regarding his ex-wife's account

Last contact with this agency: Liability Order for non-payment of Council Tax granted on 3 July 2012.

Relevance: Contact with Epping Forest District Council's Council Tax office provided the date on which GA moved to River Road.

Epping Forest District Council: Community Development

Information Supplied: Record of an incident during the week beginning 2 July 2012, recalled by a member of the Community Arts Team. MA had been taken to Loughton Youth Theatre (LYT) by her paternal grandfather. Instead of saying goodbye at the foot of the stairs, he had walked her to the first floor dressing room and had remarked to a member of staff that he wanted to make sure that MA was 'absolutely safe'.

Last contact with this agency: The incident during the week beginning 2 July 2012 was the only relevant contact with this agency.

Relevance: The Panel considered whether MA's grandfather may have been aware of issues between GA and DH. This occurred after the incident at the caravan park in Scotland and after both GA and MA had stayed in a local hotel rather than return home as GA was terrified of DH.

Staff at LYT indicated that they had not been made of aware of any child protection issues relating to MA and she had not mentioned anything at all about abuse at home. MA was never quiet or withdrawn and was known for being a very outgoing child.

Epping Forest District Council: Electoral Registration

Information Supplied:

GA was added to the electoral register for 6 River Road, Buckhurst Hill on 1 December 2011.

DH was not on the Electoral Register for the Epping Forest District.

Last contact with this agency: 1 December 2011

Relevance: Provided the date of which GA moved to River Road.

Essex Police

Unfortunately, although the IMR was dated 16 October 2012 and despite frequent requests from officers supporting the Panel, a copy was only available to Panel Members over four months later on 21 February 2012.

Information Supplied:

- Response to initial scoping exercise, providing chronology of Essex Police's involvement with DH and GA.
- IMR dated 16 October 2012 containing:
- Full report of the critical incident, including:

  Details of the procedures used by Essex Police in responding to domestic abuse incidents;

  Details of two incidents during 2010 involving GA and her ex-husband;

  Information on an incident in July 2010 involving DH and a previous partner; and

  Information relating to the incident in Scotland on 10 June 2012. A police officer in Scotland had completed a Vulnerable Person's Report, including a risk assessment. A copy of the document had been sent to Essex Police on 11 June 2012 but had not been acted upon.
- On the 23 July 2012 the Panel received copies of statements from friends and work colleagues of GA. These copies had not previously been provided to the review and were only supplied following a request from the Chair. The request was prompted by references made in the Judge's sentencing remarks to a previously undisclosed violent incident involving GA and DH

which had taken place before the murder, and the Panel were previouslyunaware it had taken place.

Dates information supplied:

31 July 2012:	Chronology received
17 January 2013:	Reminder at Panel meeting that IMR was required
25 January 2013:	Email sent to ACC Essex Police requesting IMR
1 February 2013:	Letter to ACC Essex Police requesting IMR
21 February 2013:	IMR received
23 July 2013:	Statements from friends and colleagues of GA received

Last contact with this agency: Prior to her murder, GA's last contact with Essex Police was on 7 June 2010, when she was issued with a fixed penalty notice for speeding.

Relevance:

- Essex Police had already recognised that there was a lack of clarity in the procedures for dealing with out of force incidents
- The email from Dumfries and Galloway Police was deleted without being opened. Essex Police are unable to identify how this occurred and this may have provided an opportunity for them to engage with the victim.
- Prior to the murder, Essex Police had very little involvement with the victim or the perpetrator. Therefore the Panel members believe that this homicide could not have been accurately predicted or prevented.

Essex Probation Trust

Information supplied: IMR providing a record of the transfer of a Community Order for DH from Norfolk and Suffolk Probation Trust to Essex Probation Trust in February 2011. The IMR also provided information on the management of the case and a Revocation Order made on 20 April 2012 seemingly made by magistrates on the basis that the employment arrangements for DH precluded him from compliance with the Community Order.

Date information supplied: 30 November 2012

Last contact with this agency: DH had no contact with Essex Probation Trust between the date of the Revocation Order (20 April 2012) and the date of the murder (8 July 2012).

Relevance: The IMR highlighted issues around the management of risk, in particular the assessment of low-risk offenders and ensuring this is a robust and accurate process.

In this case DH may not have had a risk of screening undertaken or, more likely he was assessed as low risk due to the time that had elapsed since his last conviction. Risk of Harm screening documents are now completed and retained on the system. The officers who dealt with the case were new in post, although their role was essentially an administrative one. They accepted the risk of harm allocated to the case and admitted that the previous convictions would not have prompted them to ask for a management review. The fact the case went to a Requirement Officer meant there was a less investigative approach. The statement about risk contained in the CPS papers was not immediately apparent nor was there a request for background information from Norfolk and Suffolk Probation Trust or Police. As a result DH slipped through the usual safeguards and was managed as a much more benign offender than he actually was.

Essex Probation has now ended the practice of allocating Unpaid Work Orders when they have other requirements to Requirement Officers. Only standalone Unpaid Work Orders are held by Requirement Officers. If DH was a transfer-in case today, he would be allocated an Offender Manager and at the very least a Layer 1 OASys would be completed.

Three internal recommendations have arisen from the DHR:

1. Relevant staff must read the case file. An accurate Risk of Serious Harm is completed and retained on the case record. This must take into account the offender's previous convictions and any other relevant material from the case file.
2. No violent offender will be assessed as low risk without the endorsement of a Manager.
3. Requirement Officers will only hold singleton unpaid work orders which are assessed as low risk of harm.

The IMR also provided additional information regarding DHs previous involvement with Norfolk and Suffolk Probation Trust.

The Panel highlighted the exemplary way in which the IMR had been completed and the usefulness of the Trust's membership of the Panel.

Essex County Council (ECC) – Children's Social Care

Information Supplied:

Information provided in response to the initial scoping exercise for the review indicated that ECC Children's Social Care had:

- No record of any Social Care contact with the family of GA or of any direct involvement from ECC Social Care staff with GA. Records were held relating to 2 notifications from Essex Police to the Social Care Initial Response Team of the Schools, Children and Families Directorate. These concerned the incidents between GA and her ex-husband on 20 January 2010 and 3 June 2010. No further action was taken on both incidents.
- No record of any Social Care involvement with MA.
- No record of any Social Care involvement with DH.

Last contact with this agency: None recorded

Relevance: Information supplied indicated that Children's Social Care had no record of involvement with the victim's family.

Loughton Health Centre

Information Supplied: DH's medical records from 1982 onwards

Date information supplied: 3 December 2012

Last contact with this agency: 30 March 2012

Relevance: The IMR identified that DH joined the practice list in October 2011 and he was seen a total of 7 times by 4 different GPs within the team whilst he was registered with the practice. On the 13 February 2012, DH disclosed he had a history of depression, and an alcohol drinking problem and had stopped cocaine use one month previously. DH was referred to the Community Drug and Alcohol Team (CDAT); unfortunately he failed to keep his allocated appointment. At his final appointment on 30 March 2012, DH again disclosed drug use in the past and that he 'continued to have binges and drug use'. The DHR identified that the practice was not aware of any previous domestic abuse issues and DH did not disclose any issues. Accordingly the practice was unaware of any wider concerns that may have been relevant to the treatment and referral decisions made.

The GP Practice requested a review of current information sharing processes in cases of domestic abuse. GP Practices are only informed of domestic abuse incidents where children are involved and made aware of cases where patients are registered with them The IMR author suggested domestic

abuse reports should be shared with both the victim's and suspected perpetrator's GP as in many cases they are registered at different surgeries.

NHS South East and South West Essex

Information Supplied: Information provided in response to the initial scoping exercise for the review indicated that DH was registered with a GP in the area from 21 December 2010 to 24 January 2011. The agency had no records relating to GA.

Relevance: Not relevant to the events that led to the death of GA

Norfolk Constabulary - Vulnerable Persons Directorate

Information Supplied:

The information given by Norfolk Police and Essex Police, using the facility of the Police National Computer, is not consistent and can not be wholly reconciled. That information includes numerous instances of arrests and sometimes charges where proceedings were either not initiated or later abandoned. The following convictions and penalties for offences of violence against individuals or property can however be identified:-

- 16 June1999: Common Assault and Harassment - Conditional Discharge and Compensation Order
- 14 June 2002; Wounding [causing victim a broken jaw] – 5 months detention in Young Offenders Institution, and Escaping from Lawful Custody - 1 further months detention.
- 3 December 2003: Wounding with intent to cause Grievous Bodily Harm [a public house 'glassing']– 9 months imprisonment
- 28 January 2011: Criminal Damage and using threatening, abusive or insulting words – a Community Order with 180 hours of unpaid work to be undertaken. That Community Order became difficult to operate because of DH's employment and was replaced by a £100 fine on 20 April 2012.
- The next conviction was for the murder of GA.

In the period from 1999 to 2012, police records refer to other allegations of violence including at least one involving a female, and of an alleged serious nature, but the woman concerned did not wish proceedings to be started, and no arrest was made. There are no recorded convictions for Domestic Violence until the murder conviction

Date information supplied: 10 December 2012

Last contact with this agency: Incident on 11 November 2011 - DH was charged with threatening behaviour under the Public Order Act 1986 and with criminal damage to a police cell. He subsequently pleaded guilty.

Relevance:

Identified that DH had a propensity for violence which was not confined to female partners and that the vast majority of the intelligence reports in respect of DH relate to the use and supply of drugs and incidents of violence. At the time, a lot of the incidents occurred, Norfolk Police had no procedures to take forward prosecutions where victims were unwilling to provide evidence or statements to support a prosecution. In a number of cases, the victims were in fear of reprisals from Hodges, either for themselves or their families.

The IMR Author advised that the co-location of police, domestic abuse, child abuse and adult abuse staff with professionals from Children's Services, Advocacy, Health and Probation in the Multi-Agency Safeguarding Hub had now led to very effective information sharing and safeguarding action

in Norfolk and should be considered elsewhere. It was acknowledged by Norfolk Constabulary that although some incidents did not lead to a charge being made, victims of these incidents could have been offered more support at the time. There are now procedures and policies in place for the police to take matters forward even if the victim is too afraid to give evidence

The IMR Author asked the Panel to question whether it was necessary to request a full IMR from Norfolk Constabulary. In response to this the Panel asked to note that through the process of carrying out a DHR and completing an IMR all forces could benefit from the learning and although it was recognised that Norfolk may now have a very effective information sharing and safeguarding process, no one should be complacent. The Panel also felt the information obtained from the IMR could be used to ascertain what processes are in place for out of force incidents affecting Norfolk and also be used for training purposes.

Norfolk and Norwich University Hospitals

Information Supplied: Record of an incident on 11 November 2010 involving DH. He had been involved in an altercation during which he had been punched and had sustained injuries to his face and left eye. He had been arrested and put in a police cell and had then injured his head by hitting it against the cell wall. He had lost consciousness and been taken to hospital.

Last contact with this agency: 11 November 2010

Relevance: This information provides an example of DH's previous violent behaviour.

Norfolk County Council Children's Services

Information Supplied: No records held relating to GA and MA. One record dated 3 December 1996 to DH, which was outside the scope of the review.

Last contact with this agency: DH 3 December 1996

Relevance: Does not fall within the scope of the Review as stated within the Terms of Reference.

Norfolk & Suffolk Probation Trust

Information Supplied: IMR containing:

- Details of three incidents involving DH in June 2002, April 2004, and on 28 January 2011
- A summary of the Trust's involvement with DH, including the transfer of his Community Order to Essex Probation Trust on 11 February 2011.

Date information supplied: 27 November 2012

Last contact with this agency: DH - 11 February 2011. Community Order transferred from Norfolk and Suffolk Probation Trust to Essex Probation Trust.

Relevance: In contrast to the Essex Probation Trust's IMR, this document lacked detail regarding their involvement with DH. However, it should be noted that the events detailed were not strictly relevant to the murder. The IMR contained some apparently contradictory statements and the Panel was disappointed that despite several requests, NSPT did not respond with clarification of these issues.

The IMR identified that the NSPT Procedure Note related to the External Transfer of Cases, where the matter is transferred to another Trust, needed to be revised. This action will be taken forward by the Director for Public Protection, to be completed by 31 January 2013.

Princess Alexandra Hospital. Harlow

Information Supplied: Record of attendances at the hospital by GA and DH and the record of MA's birth at the hospital.

Last contact with this agency: GA: 4 May 2011
MA: 26 September 2009
DH: 13 March 2008

Relevance: Not relevant to the events that led to the death of GA.

South Essex Partnership University NHS Foundation Trust (SEPT)

Information Supplied: Record of routine immunisations and child health screening for MA. There were no safeguarding issues recorded for MA or any members of the family. GA and DH were not known to SEPT.

Last contact with this agency: Not supplied

Relevance: Not relevant to the events that led to the death of GA.

St John's School, Buckhurst Hill (IMR)

Information Supplied: The school initially declined to complete an IMR. However, Essex County Councils Schools, Children and Families Directorate intervened on behalf of the Panel and worked with the school to complete an IMR. This indicated that:

- MA joined the school at the end of Reception year.
- School records from 2010 showed that the separation and divorce of her parents had a significant impact on MA and measures had been put in place by the school to try to mitigate the effects. The school had discussed issues with both parents
- There was evidence that when MA was worried or unhappy, she would seek out her class teacher to discuss her concerns.
- The school was not aware of GA's relationship with DH during the period April – July 2012. The school did not meet DH and were not aware that he attended the school on any occasion.
- MA's absence from school on 11 June 2012 (when she was in Scotland) was recorded as 'other circumstances'. GA had telephoned the school to state that her daughter would be absent from school.
- A holiday request form had not been completed for the trip to Scotland.
- During the period April – July 2012 the school did not observe any changes in MA's behaviour or presentation. She continued to be confident, with good behaviour and her attitude to learning was consistently, good while her school attendance remained unchanged.
- The school had no record of any incidents or concerns being raised.

Date information supplied: 21 March 2013
Last contact with this agency: The Headmaster spoke to GA at the end of Sports Day on 6 July 2012. She was described as "her usual self" and, as previously, did not speak about her relationship or disclose any concerns.

Relevance:
The information supplied demonstrated that MA had strong relationships with school staff and had previously discussed issues of concern with her class teacher. The school had made written records of the concerns raised in 2010 and the actions and outcomes.

It was apparent from the IMR that the school takes its safeguarding responsibilities seriously and the headmaster ensures that training in child protection is updated in line with statutory requirements. The Headmaster is familiar with Southend, Essex and Thurrock Safeguarding (SET) procedures but acknowledged that through the process of completing the IMR, a fuller understanding of the impact of domestic abuse would be advantageous. As a school considered outstanding by OFSTED, the headmaster is responsible for the training of new teachers and has committed to ensure he revisits safeguarding with particular attention to domestic abuse.

Traps Hill Surgery

Information Supplied: IMR completed which indicated that:

- GA joined the practice in November 1999
- GA attended 73 times between 1999 – 2012 (53 times to see a doctor and 20 times to see a nurse)
- No awareness of any issues between GA and DH in clinical records

Date information supplied: 11 December 2012

Last contact with this agency**:** 2 July 2012 GA visited the surgery because of back pain and minor infection.

Relevance: Identified that GA visited the doctor shortly before her murder during a period in which we now understand her to be experiencing significant domestic abuse from DH but she did not disclose any concerns to the doctor. The GP practice now intends to implement domestic abuse awareness training for all medical and administrative staff.

Victim Support Norwich

Information Supplied: Response to initial scoping exercise indicated that the agency had received a referral for DH on 31 December 2010. No action was taken as the incident related to vehicle crime.

Last contact with this agency: DH – 31 December 2010

Relevance: Not relevant to the events that led to the death of GA

Contact with Family and Friends

Family

At the request of Essex Police, it was agreed by the Panel that contact would not be made with friends or family until after the trial. Contact was made via the Police Family Liaison Officer. Letters were written explaining the purpose of the review and offering the option of face to face meetings or telephone contact. Those contacted were as follows:

M D (GA's mother)
Ma D (GA's father)
AM (GA's ex-husband and father of MA)
JP (GA's cousin)

In hindsight, perhaps the Panel should have contacted MA's paternal grandfather. However we were strongly influenced by the Police, who advised that the family of the victim's former husband would probably not want to engage with the review.

Of all the family and friends contacted, only GA's half brother AD agreed to meet with the Chair. Arrangements were made to meet in a neutral location in his home town. AD and his brother were his father's second family and they had dual English and Australian citizenship. There was a ten year age gap between him and GA; however the relationship had grown closer as they got older. In 2005-06 GA and her family visited Australia and in 2011 AD moved to England. GA had helped him

find work and a home. His father, an ex-policeman, remains based in Australia but returned to England for the trial of DH.

GA had talked about her relationship with DH and the incident in Scotland with AD but not in any detail. He believed that she and her daughter had slept in the car on the night following the incident.

GA had, at one time, disclosed to AD that she had thought of moving in with DH but was, he thought, trying to come out of the relationship. He described what GA disclosed to him as part of a jigsaw, not the full picture. He thought this applied to her friends as well, although he believed they were concerned about what GA was disclosing to them. He thought that both GA and her friends would know where to go for advice and support. However, her friends would be worried about whether it was appropriate to disclose any concerns and about the effect on their own relationship with GA if they broke a confidence. AD said there were posters in lots of places such as doctors' surgeries and on work notice boards, etc. informing where help in relation to domestic abuse can be obtained. GA did not 'come over' as a victim and he had not seen her as such. She thought she could end the relationship and do so in a way that would 'prevent setting him off'. GA was, in his words, "a strong woman - stubborn, nonchalant and independent".

AD painted a contrasting picture of DH. He described him as a "good looking Jack the lad; happy go lucky, convincing and believable but a ticking time bomb". DH drank and was argumentative.

AD described the challenge for the family of trying to cope with the murder. " You don't believe it will happen to you." No one knew how to deal with it and the awkwardness when meeting other people following the murder. He described the events as surreal.
AD found the initial meeting with Victim Support personally helpful. Through them he knew assistance was available and he felt their approach was appropriate.

AD described the investigative police team as 'second to none'. He spoke of the support for the family and how they were constantly updated. His father – an ex-policeman, also thought they had been brilliant. He also praised GA's ex-husband and his partner for their care of MA, using his partner's mother - an ex-teacher, for guidance. He noted that contact remained between the two families.

AD described his half-sister as an extrovert, an organizer, friendly and popular. "Her smile would brighten up the room". Her daughter was her number one priority, and he referred to GA speaking of MA as she was dying, with DH taunting in the background.

<u>Friends and Work Colleagues</u>

Following the conviction of DH, five friends and colleagues of GA, whose contact details had been supplied by Essex Police, were invited to contribute to the review. No responses were received.

On 23 July 2013, copies of statements made after the murder by friends and work colleagues of GA were received. Two of those who had given statements had not previously been invited to contribute to the review and contact details were requested from the police. Unfortunately these have not been received within the timeframe available for completion of the Review.

APPENDIX B

Epping Forest Domestic Homicide Review

Action Plan

	Recommendation (Reference)	Scope of Recommendation (local / regional/ national)	Action to Take	Lead Agency	Key Milestone Achieved in Enacting Recommendation	Target Date	Date of Completion and Outcome
1.	Information on domestic violence incidents to be shared with the GP surgeries where both the victim and perpetrator are registered. (R9)	Local National	Refer to Essex Domestic Abuse Strategy Group (EDASG) to consider feasibility The outcome of the local action to be referred to the Home Office to consider national implementation	Epping Forest Community Safety partnership (CSP)	Outcome of consideration	6 months	
2.	Improve training and awareness of domestic abuse for all staff in GP practices. (R10)	Local	West Essex Clinical Commissioning Group to co-ordinate training sessions Domestic Abuses awareness raising to be included in Gp Shutdown events, Practice Forums and events targeted at GP Receptionists and administrative staff	West Essex Clinical Commissioning Group	Literature on Domestic Abuse sent to all GP Practices in West Essex. Rolling programme of Training events Carried out and evaluated	Complete April 2014	Literature on domestic abyse sent to all GP Practices on 10.07.13 Basic awareness training on domestic abuse to all GP Staff delivered 11.04.13 Harlow 03.09.13 Epping

		National	All CCGs be asked to undertake a review of domestic abuse training in their GP practices	NHS England			Future events planned in Epping 24.10.13 and Uttlesford 16.04.14
3.	Mechanisms to enable third party reporting of domestic abuse to be introduced (R11)	Local National	Epping Forest CSP to work with Safer Places Harlow to promote Third-Party Reporting Outcome of media campaign will be referred to the Home Office	Epping Forest CSP Epping Forest CSP	Media Campaign and development of improved mechanisms for third party reporting	April 2014	
4.	The safeguarding training which is provided for staff in schools and children's centres should refer specifically to domestic abuse. (R12)	Local National	West Essex Safeguarding Board to review the safeguarding training provided to schools to ensure it directly refers to domestic abuse. Outcome of review to be disseminated to all safeguarding boards	Epping Forest CSP Essex County Council	Safeguarding Training in schools to refer specifically to Domestic Abuse	April 2014	

5.	That the practice of co-locating of police, domestic abuse, child abuse, and adult abuse staff with professionals from Children's Services, Advocacy, Health and Probation in the Multi-Agency Safeguarding Hub (as is the practice with the Norfolk Constabulary) be considered for adoption countrywide. (R13)	Local National	Essex Police are in the process of developing a multi-agency domestic abuse Hub in Essex National review of co-located Domestic Abuse services across Police Forces	Essex Police ACPO			
6.	A member of the police investigating team to attend a review panel meeting at the earliest opportunity after the legal proceedings had been completed, (R14)	Local National	Safer Essex Domestic Homcide Review Guidance to be amended to include the recommendation Review of training and guidance provided to CSPs	Essex Domestic Abuse Strategy Group Home Office	Amended Guidance	April 2014	

Glossary

ABH	Assault occasioning Actual Bodily Harm
CARAT	Counselling, Assessment, Referral, Advice and Drug Rehabilitation Programmes and External Drugs Intervention Teams (in prisons)
CDAT	Community Drug and Alcohol Team
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DAHCU	Domestic Abuse, Hate crime Unit (now DAST)
DAIT	Domestic Abuse Intelligence Team
DALO	Domestic Abuse Liaison Officer
DASH	Domestic Abuse, Stalking and 'Honour'-Based Violence Risk Identification Checklist
DAST	Domestic Abuse Safeguarding Team
DHR	Domestic Homicide Review
DV/1	Domestic Abuse Incident Report (current)
ECC	Essex County Council
FLO	Family Liaison Officer
GBH	Grievous Bodily Harm
IDVA	Independent Domestic Violence Advisor
IMR I	Individual Management Reviews
LYT	Loughton Youth Theatre
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment conference
PNC	Police National Computer
PROtect	Database of information on victims and suspects involved in domestic and child abuse cases
SEPT	South Essex Partnership University NHS Foundation Trust
SIO	Senior Investigating Officer
SPECCSSS	Risk assessment process (Separation, Pregnancy, Escalation, Cultural Diversity, Controlling, Stalking, Sexual Assault, Suicide)
STORM	Essex Police Control and Command system
TOR	Terms of Reference
V/1	Stalking and harassment form
VPR	Vulnerable Persons Report