Domestic Homicide Review Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Southend Community Safety Partnership

'Linda' April 2021

Independent Chair and Author: Joanne Majauskis

Preface

This tragic event resulted in the loss of two lives which has left their families devastated. I would like to begin by expressing my sincere sympathies, and that of the panel, to the family and friends of "Linda" and "Michael". We appreciate the input from them during this difficult process.

This review is into the death of Linda however much of the information contained within it will focus on Michael as this is the information that agencies held. The author did not wish for Linda to become a 'footnote' in the review and therefore asked Linda's sister to provide some words of tribute about her beloved sister.

> "Linda was an intelligent and attractive lady. She took care of herself and no one would have guessed her age at 67. She was a practical person, always cheerful and resilient, who was good at making the best of things. She was looking forward to better days ahead and her life should never have ended in the way that it did. Prior to her retirement she had a long career in the Civil Service. Well thought of by her colleagues, she was good at mentoring new staff and prided herself on providing a helpful service to the public.
>
> Linda liked needlework, reading and gardening and kept up to date with current affairs. She loved going on holiday, preferably places with beautiful and natural scenery. She was never bored with her own company, but also enjoyed socializing with close friends and family and was a much-loved Auntie.
>
> Married to Michael at just 19, he was always her number one priority. No one could have supported him more or tried harder to resolve his health issues and I know she would be devastated at the anguish and grief caused to both families by his actions.
>
> Linda was my precious sister, my only sibling – I loved her dearly and I miss her every day."

The review was commissioned by the Southend Community Safety Partnership on receiving notification of the death of Linda in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004. It follows the guidance set out by the Home Office.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address the issues that it has raised. I would like to thank all those who contributed.

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1. Review Process

1.1 This summary outlines the process undertaken by Southend Community Safety Partnership (SCSP) Domestic Homicide Review Panel in reviewing the death of 'Linda', a 67-year-old female resident in their area. Linda was killed by her husband, Michael, in the home they shared, in April 2021, he then took his own life.

1.2 The summary will refer to the life and death of "Linda" and the suicide of "Michael". These are pseudonym's chosen by Linda's family and will be used throughout this report.

1.3 The review process began when Essex Police notified SETDAB and Southend Community Safety Partnership of the homicide on 2nd June 2021.

1.4 The Domestic Homicide Review Core Group met to discuss the case on 6th July 2021 and considered the circumstances of the case, with the assistance of thorough scoping from organisations. A decision was reached that the homicide met the criteria for a Domestic Homicide Review (DHR) and an Independent Chair, Joanne Majauskis, was appointed to carry out the review.

1.5 Where it was established that there had been contact, agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members.

1.6 Agencies that were deemed to have relevant contact were asked to provide an Individual Management Review (IMR) and a chronology detailing the specific nature of that contact. The aim of the IMR is to look openly and critically at individual and organisational practice to see whether changes could or should be made to agency policies and practice. Where changes were required then each IMR also identified how those changes would be implemented.

1.7 A partnership workshop was held on 10th December 2021 to consider the case and capture key issues for this report.

1.8 Information from records used in this review was examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the review is to prevent a similar crime.

2. Contributors to the Review

2.1 The following agencies contributed to this Review through submitting a chronology and Independent Management Review:

- Essex Police
- Southend Clinical Commissioning Group/G.P. Surgery
- Southend Hospital

3. Involvement of family, friends and wider community

3.1 An introduction to members of Linda's family was made by Police Family Liaison Officers. They were given information introducing and setting out the purpose of the review, the letter included the Home Office prepared leaflet for family and friends, as well as details about AAFDA.

3.2 Michael's family, his brother and sister-in-law, were also invited to take part in the review and information regarding the review was forwarded to them.

3.3 The independent chair was in contact with the families and they were involved to the extent to which they wished.

3.4 Following the workshop, it was felt by the panel that the gun club where Michael was a member may be able to provide some useful insight. The chair spoke by telephone with the club secretary from Michael's gun club, who was also a friend of Michael's having known him for twenty years and who, prior to the pandemic, would see him on a weekly basis.

3.5 The Chair would like to thank the families and the club secretary for their engagement and contribution that they have made to this review. It has been invaluable and has helped significantly in our understanding of Linda and Michael's relationship.

4. Review Panel

4.1 The panel for this review was made up of the following representatives:

Joanne Majauskis	Independent Chair and Author	
Michelle Williams	SETDAB Domestic Abuse Coordinator	SETDAB Domestic Abuse Coordinator
Val Billings	SETDAB Domestic Abuse Coordinator	SETDAB Domestic Abuse Coordinator
Simon Ford	Head of Community Safety	Southend Community Safety Partnership
Gemma Robinson	Community Safety Strategy and Insights Manager	Southend Community Safety Partnership
Sharon Connell	Designated Lead Nurse Safeguarding	NHS Southend Clinical Commissioning Group (CCG)
Alice Faweya	MSE Named Nurse for Safeguarding Adults	MSE Hospital Trust Representative
Tendayi Musundire	Associate Director for Safeguarding	Essex Partnership University NHS Foundation Trust (EPUT)
Deborah Payne	Named Professional Quality and Governance	Essex Partnership University NHS Foundation Trust (EPUT)
Lynn Scott	Head of Adult Social Care	Southend Adult Social Care
Sarah Range	Head of Quality Practice and Principal Social Worker	Southend Adult Social Care
Paul Hill	Business Manager	Southend Safeguarding Adults Board

Jules Bottazzi	Head of the Strategic Vulnerability Centre	Essex Police
Sarah Conlon	CEO	Safe Steps
Paula Blundell	CEO	South Essex Advocacy Service

5. Domestic Homicide Review Chair and Overview Report Author

5.1 The Southend, Essex and Thurrock Domestic Abuse Board appointed Joanne Majauskis as DHR Chair and Overview Report Author in July 2021.

5.2 Joanne is an independent consultant and trainer with fifteen years' experience working in the Domestic Abuse Sector. Joanne has experience of working both in frontline and strategic management roles. Joanne has also Lectured for the National Centre for the Study and Prevention of Violence and Abuse (NCSPVA) at the University of Worcester having completed her Masters in Dynamics of Domestic Violence with Distinction in 2015.

5.3 Joanne completed Independent Domestic Abuse Chair Training with Advocacy After Fatal Domestic Abuse (AAFDA). AAFDA are a Centre of Excellence for Reviews after Fatal Domestic Abuse and for Expert and Specialist Advocacy and Peer Support.

5.4 Joanne has been working independently for two years and is not employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

6. Terms of Reference

Statutory Guidance (Section 2.7) states the purpose of the DHR Review is to:

6.1. Establish what lessons are to be learned from the domestic homicide involving Linda and Michael regarding the way in which local professionals and organisations work individually and together to safeguard victims;

6.2. 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;

6.3. Apply these lessons to service responses including changes to policies and procedures as appropriate;

6.4. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter- agency working.

6.5. Contribute to a better understanding of the nature of domestic violence and abuse and highlight good practice.

Specific Terms of Reference

6.6 This report of a Domestic Homicide Review will consider relevant past agency contact and involvement with Linda and Michael and in particular will focus on the time from September 2017 until the time of the incident. At this time Michael suffered a significant health issue which appears to be the start of ongoing health problems which form part of this review.

6.7 The independent chair agreed the Terms of Reference for the Review with the panel. The family were also consulted and added to the themes that were considered. The key issues identified were:

- What processes are in place when renewing a shotgun license, are spouses/family members included in this process?
- We understand from the family that Linda was trying to get help for Michael for his mental health, do we know what help and from whom?
- Do G.P.s do any assessment on quality of life/impact on mental health for people with long term ill health?
- We understand that Linda and Michael were in the process of changing G.P. surgery, what was the reason for this?
- Was it usual for Michael to contact the G.P. by letter?
- Did Michael and Linda have any financial issues that could have been a contributing factor?
- Was isolation a factor and specifically was the pandemic also a factor in isolation and accessing healthcare?
- Were there any signs, signals or concerns regarding domestic abuse or coercive controlling behaviour? If so, how was this addressed?

6.8 Agencies completing IMRs were required to analyse these issues in relation to their contact with Linda or Michael, with specific reference to:

- What policies, procedures and guidelines provide the framework for the agency's response to the above issues.
- What training is available to, and accessed by, staff in relation to responding to the above issues.
- What communication should have taken place between agencies in relation to the above issues; whether this took place; the quality and outcomes of that communication.

7. Summary of the Chronology

7.1 There was very little agency contact with either Michael or Linda. The only information regarding Linda was held by the CCG for routine health visits. Most of the information related to Michael's health, which formed a significant part of the review.

7.2 Michael's health issues appear to have begun in September 2017 when he was admitted to Intensive Care and High Dependency Unit at Southend University Hospital following a ruptured right common iliac aneurysm. An iliac aneurysm is a bulge and weakness in the wall

of the iliac artery, found in the pelvis. When iliac aneurysms burst, it can cause life-threatening, uncontrolled bleeding.

7.3 Between 2019 and 2021, Michael attended the Accident and Emergency Department at Southend University Hospital on five separate occasions. Presenting with a range of health issues on each occasion including an atrial fibrillation (an irregular and very rapid heart rhythm), nose bleeds, lower limb pain, shortness of breath, tingling hands, bloating, weight loss, poor appetite and diarrhoea.

7.4 In March 2021 Michael wrote to his G.P. to ask for a referral to a gastroenterologist for constipation. Michael ends the letter by saying, "I can't go on living like this. If my digestion was sorted out, I could live a normal life again. I hope you can help me".

7.5 In April 2021 the East of England Ambulance Service respond to the homicide incident. It is reported that the deaths occurred sometime within a six-day period.

8. Key Issues arising from the review

8.1 There is no information recorded in any of the participating agency files who came into contact with Linda and Michael to indicate that there were any issues relating to domestic abuse prior to the murder. To the contrary, reports from family and friends portray Linda and Michael as a happy and loving couple.

8.2 Discussion on the issuing and ownership of firearms formed a large part of this review. In particular, the procedures for renewing shotgun licences, the monitoring of licence holder's mental health and barriers to licence holders disclosing declining mental health. Linda's family hold strong views regarding this subject, and these were taken into consideration. However, it is important to note that Michael was a licenced firearm holder for over 30 years without incident. It was clearly a hobby he loved and a big part of his life.

8.3 Michael's health was a significant theme in this review. Family input gives an insight into the impact that Michael's physical health had on his mental health. Previously of good health, his ongoing health concerns had a significant impact on his quality of life and prevented him from engaging in hobbies and activities he enjoyed. Linda's sister says she feels Michael was overwhelmed by the thought of more medical tests and believes this led him to feeling "he could no longer go on, but that he could not leave Linda alone to cope without him."

8.4 It is important to acknowledge that at the time of the incident in April 2021 the COVID-19 pandemic was at its height in terms of impact on day-to-day life in England. It is widely reported that the pandemic had a detrimental impact on some individual's mental health, particularly older people (McKinlay, 2020; Ipsos Mori, 2020) and it was felt by family members and by Michael's associate that the pandemic was without doubt a factor in this tragedy.

9. Conclusion

9.1 This tragic loss of two lives has left their families devastated. It can never be known whether different actions would have resulted in a different outcome, but we hope that the lessons learnt, and the changes made as a result of this review are able to give them some comfort in that others will be better protected. Our thoughts are with both families.

9.2 There was little information available to the panel, but certain themes emerged that are addressed here and in the recommendations.

9.3 Whilst it can never be known with complete certainty, there was no evidence to suggest that, prior to the tragic incident, there was any violence or abuse in their relationship. To the contrary, family narrative suggests a long and loving marriage.

9.4 Family anecdotes also paint a picture of a formerly fit, healthy and active man whose life had become limited due to health issues. The limitations on life imposed due to the pandemic had added to this. These two things prevented him from his usual hobbies of cycling and shooting.

9.5 There was nothing in the information known to Essex Police that could or should have alerted them to the changes in Michael's physical or mental health, or to the risk that he posed to Linda and himself. Particularly, given that Michael had held his licence for over 30 years without incident.

9.6 The Review did not identify any missed opportunities by the Force to safeguard Linda or to prevent Michael's actions, such as would have changed the tragic events of April 2021. However, it does highlight the link between mental health and the risks associated to firearms ownership.

9.7 The risks of firearm possession are well understood by police and the possession of firearms in the UK is subject to a robust national licensing framework. Recent updates to the guidance and legislation underline the critical importance of ensuring effective disclosure of medical information between certificate holders, G.P.s and firearms licensing departments.

9.8 Linda's sister had strong thoughts on the ownership of firearms and gave her permission for them to be shared in the report: "It would be my wish that guns are never allowed to be legally stored in anyone's home. But I recognise that bringing in such a measure would never even be considered, never mind passed, due to strong opposition from gun club members. It is ironic that 'Michael' was a vociferous campaigner against the changes bought in following the Dunblane massacre – saying it was an over the top, unnecessary, knee jerk reaction taken against legitimate gun licence holders. Yet when his mental health declined, look at the tragedy that occurred…and which could have been avoided if he was not allowed such easy access to lethal weapons in his own home. But I suppose we must be grateful that we do not live in the USA, that we do at least have a gun licensing authority and that the flagging of medical records has been reviewed and improved recently."

9.9 Essex Police state that they are already working with partners and certificate holders to reduce barriers to reporting and encourage information sharing. New statutory guidelines should serve to further strengthen the requirement for G.P.s to have effective monitoring and reporting processes in place.

9.10 The new guidance requiring medical screening reports removes the reliance on the certificate applicant declaring their current and/or past medical issues and allows police to have factual medical information which should help reduce the potential risk of that individual having a firearm or shotgun certificate.

9.11 We can speculate that in some cases, as appears here, that the ownership of a firearm or shotgun licence can be a barrier to a disclosure of declining mental health. This is one of the main learning points from this review. Further work with certificate holders, gun clubs and the wider shooting community must be encouraged to enable certificate holders to reach out and seek help, even where it may impact on their ability to hold a firearm licence.

9.12 The discussion regarding disclosure of information also highlighted the issue of how agencies share information. Currently there is a reliance on either a disclosure from the licence holder or from the G.P. regarding mental or physical health conditions. However, it may be possible that other agencies hold relevant information about the licence holder that may affect their suitability to hold a licence.

9.13 Furthermore, a firearm licence holder may be working with services who would benefit from knowing that they are in possession of a firearms licence so that they can assist in the monitoring of that individual and to inform their own risk if, for instance, they are conducting home visits.

9.14 This review also highlighted the importance of professional curiosity and the opportunity for routine enquiry. NICE Guidelines state, "Professionals should maintain professional curiosity and questioning while building a good relationship". The SET Safeguarding Guidelines April 2019, states "Professional curiosity is the capacity and communication skill to explore and understand what is happening within an adult rather than making assumptions or accepting things at face value. Professional curiosity can require practitioners to think 'outside the box', beyond their usual professional role, and consider circumstances holistically. Curious professionals will spend time engaging with adults. They will ask questions (in an open way) and seek clarity if uncertain and will be open to the unexpected".

9.15 The MSE Foundation Trust recognised in their IMR a potential missed opportunity to ask Linda about any experiences of domestic abuse when she presented with a condition that could have been stress related. There is no evidence of domestic abuse in this case, and it is doubtful that this would have resulted in a disclosure, however, routine enquiry in healthcare is promoted as best practice in the NICE guidelines.

9.16 The importance of asking about a patient's mental health when they are experiencing physical health issues over an extended period of time should also be considered. Michael's mental health declined over a period of time and does appear to be linked to his physical health issues. Of particular note, is the letter he wrote to his G.P. where he alludes to his mental health and was not responded to. It is imperative that we employ professional curiosity and spend time communicating with individuals in order to understand them and their needs holistically.

9.17 Lastly, it is important to acknowledge the unprecedented circumstances the world was experiencing in the year leading up to the tragic event in April 2021. It is clear that the pandemic led to many people being isolated from both services and more informal support networks. Whilst we may never be able to understand what could have happened if that support was there, we can recognise that the loss of those networks is likely to have been a

significant factor in this case, in particular when looking at isolation and an acute deterioration in mental health.

10. Recommendations

10.1 The guidance on the licensing of firearms has been thoroughly considered as part of this review. It is without doubt that recommendations would have been made here regarding the ownership of guns and the monitoring of mental health. However, new guidance and legislation on the licensing of firearms has come into effect since Linda's murder and Michael's suicide that has put more stringent measures in place and seeks to address the issues associated with the disclosures of medical conditions that could impact on an individual's suitability to possess a firearm.

Recommendation One:

10.2 Primary Care practices to ensure all communications from patients and their significant others are responded to in an appropriate and timely manner. Guidance on timelines for responding to communications should be set out in policy and procedures. A self-audit of communications received should be completed and sent to the Head of Safeguarding to have an overview and allow them to share any learning from this exercise on a wider scale.

Recommendation Two:

10.3 CCG to provide training to G.P.s on the importance of professional curiosity, with a focus on routine enquiry about mental health for individuals presenting with poor physical health, particularly where that has a significant impact on their quality of life.

Recommendation Three:

10.4 Mid-South Essex NHS Foundation Trust to review safeguarding and domestic abuse training to promote good practice when asking about domestic abuse. In particular focusing on the importance of professional curiosity.

10.5 In response to this review the Mid-South Essex NHS Foundation Trust have reviewed and rewritten their Domestic Violence Policy to provide clear guidance to staff on selective or routine domestic abuse enquiry and the use of professional curiosity and challenge.

Recommendation Four:

10.6 Firearms Suicide Prevention Workshops are already being conducted by Essex Police. Essex Police to widen the range of participants to include other healthcare professionals and multi-agency groups involved in safeguarding Domestic Abuse victims and protecting Vulnerable Adults. Thus, sharing the knowledge of the risks associated with mental health and the ownership of firearms and promoting links across agencies.

Recommendation Five:

10.7 Essex Police to form a working group with the relevant partners of Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board (SETDAB) to better understand if there is a method of providing firearms licensing information to agencies

involved with persons in potential risk situations. *(This recommendation is repeated in another DHR underway)*

Recommendation Six:

10.8 The Home Office should initiate discussions to establish if the National Firearms Licencing System could be made available on a restricted basis to appropriate partners for the purpose of managing and mitigating risk. *(This recommendation is repeated in another DHR underway)*

Recommendation Seven:

10.9 The Home Office to consider a review of gun licencing protocols to include mandatory questioning of household members with the intention of managing the risk where there is unknown or undisclosed domestic abuse.