SETDAB
Southend, Essex
& Thurrock Domestic
Abuse Board

# Domestic Homicide Review

## Harlow Community Safety Partnership

## Bob died February 2022

## Executive Summary

Report Author Katie Bielec

18th July 2023

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## Foreword

The Foreword is made up of memories from Bob's family and close friends.

Bob worked hard as a cabinet maker and took pride in his work. He was a sociable character, loved to socialise with a pint. He was happy go lucky and football mad, he loved Tottenham Hotspurs. As a brother he was loving, caring and full of wise words, and when he had a drink, we only heard words of love and affection, never any aggression. Bob was an exceptionally loyal man; notably caring, warm, and kind, with an inherent desire to protect those he loved and who loved him, he was the gentlest, most loving, and loyal person. He would do anything for you, and we never felt anything other than being loved and safe in his presence. He loved to laugh and share the warmth and love he had for his family and close friends.

The entire process has been extremely emotionally draining and stressful for the family starting with one of his sons having to identify his body. It has been extremely hard to have no explanation or understanding as to why Bob lost his life. Our family cannot understand why a trained and 'dedicated' nurse left Bob to die whilst she was downstairs refusing to give first aid. We have been unable to identify any emotional or real remorse from Clare. It has also been hard to hear him be painted as an aggressive and violent drunk who would regularly harm Clare when we have only experienced a kind, gentle and loving man.

Bob will never get to meet his grandchildren, his great nieces, and nephews. A huge hole has been left in our family. Bob might be lost to us physically, but he is with us forever in spirit, we love you forever.

## Preface

Harlow Community Safety Partnership (CSP)[1], panel members and the author wish at the outset to express their deepest sympathy to the family of Bob. This review has been undertaken in order that lessons can learnt; we appreciate the engagement from his family throughout this difficult process. The chair of the review aimed to work with the family sensitively and with compassion.

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 death in a meaningful way and address with candour the issues that it has raised.

## 1. Introduction

**1.1** This review is a statutory requirement which will examine agency responses and support provided to Bob (not his real name) and that of Clare (not her real name) prior to his murder. The Executive Summary summarises the events leading to Bob's death and the conclusion of the panel's findings. For full analysis into the interaction agencies had with both Bob and Clare please refer to the Overview Report.

[1] CSP – Community Safety Partnership

## 2. Timescales

**2.1** In February 2022 Bob was murdered by his wife Clare who he lived with in Harlow. Harlow Community Safety Partnership received a Domestic Homicide Review referral from Essex Police, the decision to carry out the review was made in March 2022, an Independent Chair and Report Author was commissioned in April 2022.

**2.2** The Home Office Multi-Agency Statutory Guidance for Domestic Homicide Reviews 2016, paragraph 46 states that the target timescale for completion of the review of six months. Initial information was sought by Southend, Essex, and Thurrock Domestic Abuse Board (SETDAB)[2] to ensure different agencies were aware of the DHR and the requirements as well as the introductory panel meeting. However, the review was unable to be completed in six months due to the on-going criminal case which concluded in September 2022, which caused a delay in any contact with family, friends, or colleagues. Additional detail was also required by the chair causing further delay. This delay was approved by Harlow CSP and the panel, there were a total of 4 panel meetings for this review.

## 3. Confidentiality

**3.1** In line with Home Office Statutory Multi-Agency Guidance paragraph 75, to protect the identity of those involved and to comply with the Data Protection Act 1998 pseudonyms have been used which were chosen by Bobs' family and agreed by the panel.

**3.2** The sharing of information between agencies in relation to this review was underpinned by the Information Sharing Protocol which is in place to facilitate the exchange of personal information to comply with the requirements of Section 9 of the Domestic Violence, Crime and Victims Act 2004.

**3.3** Panel meetings were confidential and any sharing of information to third parties was carried out with the agreement of the responsible agency's representative, the panel and chair.

**3.4** The findings are restricted to authors of the reports, their managers and panel members. Once agreed by the Harlow CSP, the Home Office will be informed and will be presented for final approval. Initial learning identified through the review process will be acted on immediately.

## 4. Methodology

**4.1** DHRs became statutory in 2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states: 'A DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:
a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death'.

[2] SETDAB - Southend, Essex and Thurrock Domestic Abuse Board

**4.2** Agencies were identified to provide IMRs[3] after scoping was completed across the Essex area. The terms of reference were provided to all agencies completing IMRs. All reports, learning, recommendations, and actions were quality assured by senior members of staff within each organisation.

**4.3** In addition to the IMRs provided by agencies the chair was also provided with:
- Invaluable family insight into Bobs' background and his relationship with Clare.
- Statements made by family for the criminal trial.
- Judge's sentencing remarks.
- Criminal court agreed facts.
- Recording of the 999-call made to Police by Clare.

**4.4** Various pieces of research have been used within the analysis and are referenced throughout.

## 5. Involvement of family and friends

**5.1** Bob's family were informed of the DHR by letter, they were referred to Victim Support – Homicide Support Team and were supported by an advocate from this service. The chair remained in contact with the family and advocate throughout the entirety of the review.

**5.2** After the criminal trial Clare was informed of the DHR, provided with the Home Office Statutory Guidelines, and offered the opportunity to meet or speak with the chair, unfortunately, this was declined. No details were available regarding contact with Clare's family however her colleagues were spoken to by the chair.

## 6. Contributors to the review

**6.1** IMRs were provided and presented to the panel by:
- Essex Police
- Essex Partnership University NHS Foundation Trust (EPUT)
- Hertfordshire & West Essex ICB

**6.2** The panel comprised of agencies recommended within the statutory guidance, specialists for domestic abuse, male victims, and Clare's employer (EPUT). The review panel consisted of:

| Agency | Representative and role |
|---|---|
| Chair | Katie Bielec |
| Essex Police | DS Ben Pedro Anido - T/Detective Inspector, Head of Operational Development within the Strategic Vulnerability Centre<br>Jules Bottazzi - Head of Strategic Vulnerability Centre<br>DS Scott Kingsnorth - TSA DI \| T/Head of Operational Development, Crime and Public Protection Command<br>DI Lydia George - Senior Investigating Officer (SIO) |
| Hertfordshire & West Essex Integrated Care Board (ICB) | Beaulah Chizimba - Interim Designated Nurse Safeguarding Adults<br>Zivai Muyengwa - Designated Nurse Safeguarding Adults |

[3] IMR - Individual Management Review require agencies to look openly and critically at individual and organisational practice.

| Harlow Community Safety Partnership | Christine Howard - Strategic Manager for Community Safety, Youth and Engagement / Designated Safeguarding Officer |
|---|---|
| SETDAB Team | Emma Tulip-Betts – Specialist Wellbeing & Public Health Officer |
| Essex Partnership University Foundation Trust (EPUT) | Nicole Rich - Director West Essex Community Physical and Mental Health Services<br>Tendayi Musundire - Associate Director for Safeguarding |
| Adult Social Care – Essex Council | Elaine Oxley - Director of ASC Safeguarding and Quality Assurance |
| Next Chapter (Domestic Abuse Service) | Nicola Taylor – Service Manager |
| Male Victim Specialist Service - Safer Places | Gemma Toynton – Independent Domestic Violence Advocate (IDVA) |
| Open Road – Substance Misuse Service | Joni Thompson - Clinical & Business Development Director |
| Alpha Vesta | Lucy Whittaker - Chief Executive Officer |

## 7. Author of the Overview Report

**7.1** Katie Bielec is an independent domestic abuse consultant, she is an accredited chair with AAFDA[4] and SILP[5] and MARAC[6] , has completed the Home Office Domestic Homicide Review Training, is a member for AAFDA DHR Network, Standing Together Against Domestic Abuse Coordinated Community Response (CCR) and The Employers Initiative on Domestic Abuse (EIDA). She is an associate trainer for Safelives, Rockpool, The Hampton Trust, a guest lecturer at Bournemouth University and is an accredited trainer delivering Coercive Controlling Behaviour and Stalking. Katie was previously a Metropolitan Police Officer, she is a qualified IDVA, IDVA manager, ISVA[7] Manager and managed domestic abuse services for 11 years.

**7.2** Katie is not associated in any way to any agency who have provided information for the review or had any personal or professional involvement with Bob, Clare, or their families.

## 8. Parallel Reviews

**8.1** A criminal trial was held in August 2022, Clare was found guilty of murder and sentenced to life in prison with a minimum of 17 years.

## 9. Equality and Diversity

**9.1** The chair and panel members considered whether any of the protected characteristics within the Equality Act 2010[8] were relevant within the review. Bob was a 57-year-old white British male; Clare is a white British female and was 51 years old at the time of the murder. Bob did not have a disability; Clare had been diagnosed with fibromyalgia, this was not recorded as a disability and no information was provided to believe either had any religious beliefs.

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[4] Advocacy After Fatal Domestic Abuse - https://aafda.org.uk/
[5] https://www.reviewconsulting.co.uk/silp-reviews/
[6] MARAC – Multi Agency Risk Assessment conference.
[7] ISVA – Independent Sexual Violence Advocate, support for victims of sexual violence/abuse.
[8] https://www.gov.uk/guidance/equality-act-2010-guidance

**9.2** Bob's sex was taken into consideration for this DHR as a risk factor due to domestic abuse and domestic homicides of men with female perpetrators being significantly fewer than female victims and male perpetrators. A recent review of DHRs found 20% of victims were male with female perpetrators equating to 17%[9]. Therefore, the panel felt it important to understand if Bob faced barriers in identifying the abuse and seeking support as well as agency responses.

## 10. Dissemination

**10.1** Bob's family and all agencies involved in the review are aware that the Overview Report and Executive Summary will be published on the SETDAB website[10] and shared with Safer Harlow Partnership Board, Essex Police Fire &Crime Commissioner and the Domestic Abuse Commissioner once agreed by the Home Office; however, the action plan has already been disseminated with all relevant agencies to ensure immediate action and learning can be taken forward. Harlow CSP and chair will work with the family and other partners with regards to any public/press interest.

## 11. Homicide the facts

**11.1** The night prior to Bob's death, he had been to a public house where he met friends, Clare had been at work (as a community nurse) with a fellow colleague and student, her shift finished at 23:00 hours.

**11.2** When he returned home, Clare was already at the property and was using the computer which was situated downstairs. The couple drank alcohol together, at some point during the evening Clare alleged Bob called her '*worthless and/or useless*'. At about midnight Clare supported Bob upstairs, helped him to get into his pyjamas and into bed. She went back downstairs, continued to drink red wine, and search the internet whilst Bob went to sleep.

**11.3** Shortly after 02:00 hours the following morning Clare went to the kitchen, selected a knife, went to the bedroom where Bob was asleep, and stabbed him twice in the stomach. She called 999 and requested ambulance and police. Clare refused to provide Bob any help whilst on the phone to the call handler who repeatedly asked her to stem the blood flow. Paramedics attended the address and took Bob to hospital where he underwent surgery but later died.

**11.4** Toxicology found Clare had 138 milligrams and Bob had 152 milligrams of alcohol per 100 millilitres in their blood at the time of the murder[11].

## 12. Family and relationship background

**12.1** Bob was born in Enfield in 1964. His mother passed away in 2012, his father was 89 years old (at the time of Bob's death), and he had two siblings an elder and younger sister. The family moved to Harlow in the 1970s and have remained there ever since. He met his ex-wife Joyce (not her real name), and they had three children together (all are now adults), after the marriage ended the children remained living with Joyce, however, Bob saw them regularly.

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[9] https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews#introduction
[10] https://setdab.org/
[11] 80 milligrams of alcohol per 100 millilitres is the legal limit to drive a car.

**12.2** In 2004 Bob met Clare at a local social club and married in 2007, she had never been married and had no children. Clare wanted children but Bob had not wanted any more, this apparently caused some resentment and jealousy in his relationship with Clare. Bob worked for a local furniture company (however, he identified to agencies as a self-employed carpenter), and Clare had been a community nurse in the Harlow area for 16 years.

**12.3** Bob would attend the local public house with his father every Friday to play darts and his father would go to the couple's home every Sunday for lunch. He continued contact with his sisters; however, this was limited due to Clare's behaviour whilst intoxicated.

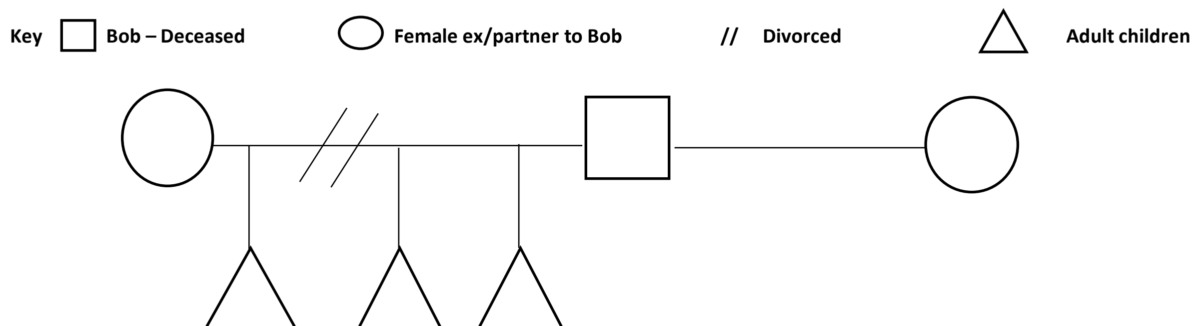
**12.4** The family witnessed Clare being violent and abusive to Bob, both within the family home and in public. The impact of the abuse meant Bob's children had limited contact with him for several years, however, after the COVID restrictions were lifted (summer of 2020) Bob began to rebuild his relationship with his youngest son.

**12.5** The family do not believe Bob would have identified himself as a 'victim' of domestic abuse although he recognised his relationship was not healthy and at times 'toxic'. They refer to Bob as a dedicated husband, Clare was his priority, and he was committed and loyal to her. They are clear they do not believe he would have sought support regarding the abuse. They describe him as very private, and they do not believe even if they or friends had approached him, he would have made any disclosures.

**12.6** Clare has two brothers (who do not live locally to the Harlow area), they had limited contact, and any communication was via phone calls, both Clare's parents have passed away.

**12.7** Unfortunately, the review was unable to speak with Bob's colleagues, however Clare's colleagues engaged with the review. They described her as a kind, compassionate and patient nurse who loved her job and worked very hard. She was proud of her work and wanted to a happy life, everyone went to her for advice or support, and she always worked at a fast pace. They were completely shocked and devastated by her actions. Until she was promoted, she also worked as a bank nurse for a private health care service. Clare did not socialise or have contact with her colleagues outside of work and would only attend organised 'work nights out', during these occasions her behaviour had not raised any concerns when she had been drinking.

## 13. Genogram



## 14. Chronology

**14.1** Details relevant to the review have been identified outside the timeframe set in the terms of reference, unfortunately information is limited, however, the following has been established:

**14.2** 2002 Joyce reported to Police that Bob had caused her alarm and distress and criminal damage to her property, he was intoxicated at the time, and he pleaded guilty at court.

**14.3** January 2004 Police were called to a verbal disagreement between Bob and Clare, both were under the influence of alcohol. Bob had an injury to his knuckle but gave no information in how he sustained the injury. No complaints were made, and no action was taken.

**14.4** In December 2004 Clare called Police stating Bob had punched her in the mouth causing cuts and swelling. Bob stated he had attempted to restrain Clare resulting in her biting his calf causing bruising, this occurred in front of Bob's children. No further action was taken by Police.

**14.5** Between 2008 and 2018 Clare's colleagues noticed that Clare would go to work with bruises, black eyes, bruising around her wrists, broken ribs and she was at times very distressed due to the environment at home, her colleagues were aware of the domestic abuse.

**14.6** In May 2010 Clare called Essex Police on 999 stating that she had been assaulted by Bob at their home address, Bob was arrested and taken into custody. Clare was intoxicated so seen later that day, providing a statement and photographs of her injuries. She alleged Bob had also assaulted her in February 2010 pushing her over causing her to fall against a coffee table cracking a rib. A DASH RIC[12] was completed, she was assessed as high risk. Bob was interviewed, charged with assault (battery), and bailed with conditions whilst he awaited trial.

**14.7** Clare informed a Domestic Abuse Liaison Officer (DALO) she was seeking advice from a solicitor regarding a divorce, she declined all other support but expressed anxiety about giving evidence at court. In August 2010 Bob appeared at Magistrates Court where CPS[13] offered no evidence, and the case was dismissed, the reasons for this were not recorded.

**14.8** January 2016 Clare presented at her GP[14] surgery on three occasions, on each occasion she was seen by a different GP. She disclosed pain in her back, rib cage, general pain on both sides of the chest wall, pain in her right leg and left arm as well as feeling generally tired. She also informed the GP she was a heavy cigarette smoker; it was also identified her cortisol levels were high. She was given the diagnosis of fibromyalgia and issued a 'not fit for work' note.

**14.9** In June 2016 Essex Police FCR received a non-emergency call from Clare. She had fled the home address after being involved in a domestic abuse incident with her partner (she did not disclose who her partner was). The incident was graded as a Priority 1(Urban Emergency), and she was taken to a Police Station where she gave a statement.

**14.10** Clare stated the day before she had met up with a close male friend who she had known for twenty years; she had no other close family or friends. She then met Bob at a local public

[12] DASH RIC – Domestic Abuse, Stalking and Harassment Risk Indicator Checklist
[13] Crown Prosecution Service
[14] GP – General Practitioner a medical doctor who treat acute and chronic illnesses and provides preventive care and health education to patients.

house where they had a few drinks before returning home. There was an argument, Bob slammed a cupboard door resulting in a glass being smashed. He had then grabbed her to the back of the head and with the other hand had hit her on the forehead with a glass ashtray causing an injury (lump to forehead). She had left the home fearful of what may happen next.

**14.11** The allegation was 'crimed' and a DASH RIC completed. During the assessment Clare described an assault where Bob had used a piece of wood and threatened to kill her (this had taken place six-seven years earlier). She spoke of historical strangulation, jealousy, and feeling isolated. As a result of the information Clare was assessed as high risk, Bob was arrested on the same day at the home address for the offence of Actual Bodily Harm (ABH).

**14.12** Bob was interviewed under caution; he gave an account in which he stated an argument had occurred at the home address which resulted in him slamming a door causing a glass to break. Clare had then struck him on the chin with an ashtray (when arrested and entering custody it was noted that he had a cut to his chin), he had reacted by holding the back of Clare's head and pushing the ashtray hard against her forehead asking her, "*how do you like it?*". After he let her go, Clare threw a glass at him and then left the home address. Bob accepted that what he had done was wrong and he should have walked away but had reacted after being assaulted. Following the interview Clare was spoken with by the case officer where she confirmed that she had hit Bob first with an ashtray causing the injury to his chin.

**14.13** Clare was advised that a file would be submitted to the CPS and that Bob would remain in custody whilst advice was sought. Clare declined to provide a statement informing that she would not support a prosecution, nor would she attend court. The CPS determined the required threshold test had not been met and no further action was taken in relation to criminal charges. However, given the allegation provided by Clare and the assessment of risk a DVPN[15] was authorised and served on Bob prior to his release.

**14.14** Essex Police referred Clare for IDVA support[16] and MARAC. The Domestic Abuse Specialist Officer (DASO) made attempts to contact Clare by phone, but she did not answer the calls, a discreet message was left on her answer phone. A skeletal safety plan was created by the DASO including flagging her home address and phone and to treat all calls as urgent.

**14.15** Bob appeared at the magistrates' court two days after the initial allegation where a DVPO[17] was granted for fourteen days. Police contacted Clare on the day of the DVPO, she told the officer she could not speak and hung up, the investigation was filed.

**14.16** The case was heard at MARAC, present were Children's Health, Children's Social Care and Police. The only organisation to share information for the MARAC Action Plan was the Police, there was no IDVA update, so engagement was unknown. There is no record of Clare being aware of the MARAC or being contacted after the meeting with any updated actions.

**14.17** Clare disclosed to a colleague that Police had been called. She told them she loved Bob and could not go through with taking him to court. There had been discussions of her leaving, but she had stated she did not want to leave him, her home, or her cats so felt it was never a

[15] DVPN – Domestic Violence Protection Notice - A temporary protective order granted by the courts for victims of domestic abuse where police.
[16] The IDVA provider at the time had no information to share due to their Retention Policy had recently changing from 2 years to 5 years.
[17] DVPO – Domestic Violence Protection Order – Temporary Protective Order granted by the courts when there are no other enforceable restrictions.

realistic option for her. Staff stated it had become the '*norm*' for Clare to come in with injuries, a colleague had raised her concern with a manager and there was an assumption management were supporting her. There is no recorded evidence Clare was spoken to by her manager.

**14.18** In June 2017 Clare was seen by the Physiotherapy assessment and treatment team due to back pain (reason provided was due to her work as a nurse) and discharged in August 2017.

**14.19** Clare was promoted to a Band 6 community nurse in January 2018. In May 2018 she experienced a sudden bereavement and saw her GP who provided a 'not fit for work note' due to stress and was off work for twenty days.

**14.20** The GP contacted Clare by telephone regarding medication for her back pain in November 2018, she was offered a face-to-face appointment where medication was reviewed, no details of the cause of back pain was documented. She then attended A&E regarding chest pains, palpitations, and muscular pains (detail of the cause or treatment provided was unavailable).

**14.21** Bob's GP referred him for an orthopaedic appointment due to problems with neck pain after an incident carrying a large board in January 2019, an appointment was made for February.

**14.22** In February 2019 Clare was seen at the GP surgery with rib pain from a fall on the stairs, medication was requested (it is not documented what caused the fall or if medication was provided). She disclosed to the GP in April 2019 that she had fallen on the stairs three weeks previously, she had fallen headfirst and sustained facial bruising (there is no record the cause of the fall and if this was the same fall in February). She was advised against different remedies, to exercise, and self-refer for physiotherapy, she was diagnosed with neck pain.

**14.23** In June 2019 Clare had two days of sickness at work citing anxiety/stress/depression. The GP received a letter from Healthy Minds (a psychological service) in July who saw her for insomnia and depressive disorder. She was advised to start Mirtazapine with a six–eight-week review (there is no indication that this happened).

**14.24** Clare attended the GP on two occasions in December 2019 and was provided a 'not fit for work' note citing stress (her absence report at work cites anxiety/stress/depression/other psychiatric illnesses). No details were recorded with regards to the cause of the stress.

**14.25** Whilst off work, EPUT referred Clare to Occupational Health in January 2020, provided her with the Employee Assistance Programme (EAP) contact details and advised to see her GP as soon as possible for support. A further Occupational Health telephone review was arranged for February 2020. Clare did not contact the EAP as advised. Clare kept EPUT updated with regards to the Healthy Minds follow up and GP advice, she was off work for a total of 118 days and returned with a recommended three-week phased return by Occupational Health.

**14.26** The UK experienced the COVID Pandemic from March 2020 with the population subjected to a nationwide lockdown between 23/03/2020 – 21/06/2020, with a gradual easing of restrictions throughout the summer of 2020.

**14.27** In July 2020 Bob was referred for Physiotherapy due to his neck pain not improving. In September Bob attended A&E (alone) after he had fallen and slipped down the stairs six weeks

earlier. He received a hip examination; X-ray of his pelvis and the GP was notified of his attendance. There is no record of the cause of the fall. In October he saw his GP due to 'hip power' and knee buckling/giving way, this was attributed to potentially a result of heavy lifting. Clare also saw her GP reporting her being stable on Citalopram.

**14.28** There were two further lockdowns in November 2020 and January 2021 with phased 'easing of restrictions' until June 2021.

**14.29** Clare reported to her GP in February 2021 that she had twisted her knee twice but did not want to bother anyone during COVID and bought a support from Boots. She reported to have fallen after she had missed a step resulting in a swollen knee.

**14.30** Clare was referred to Occupational Health in March 2021 after an MRI scan identified arthritic changes and damage to Anterior Cruciate Ligament. Clare was advised to wear a knee brace and take anti-inflammatory medication. She was unable to bend down and had difficulty getting up, it was recommended work restrictions for three months with no heavy lifting and to only drive locally if fit and to return to work for office type duties.

**14.31** At the end of March 2021 Bob attended a health check, during this appointment he was asked about his alcohol intake and stated he drank one or two units. When asked how often he drank eight units or more on one occasion he stated weekly. He was asked if he or anyone had been injured because of his drinking he replied 'no'. Bob said no relative, friend or professional had been worried about his drinking. He identified himself as a smoker and did not want to quit.

**14.32** The GP issued Clare a 'not fit for work' note (no details provided with regards to the reason) in April and May 2021. It was recorded within her work Absence Report this was for 'Other musculoskeletal problems', she was off from work for a total of 106 days.

**14.33** Two weeks prior to Bob's death Clare sent several text messages to a colleague (on a work phone), one stated she was an alcoholic and she wanted to take her own life. She declined the offer to be collected by the member of staff. Concerns were raised to a manager with regards to Clare's welfare and her patients. The manager sought advice for Clare's mental health via the organisations 'Hear for You' advice and support where they were advised for her to contact the EAP or the crisis team on 111. This advice was given by the manager, unfortunately there is no record to evidence the concerns of her alcohol use were raised or discussed.

**14.34** A few days later Clare's colleague contacted 'Staff Engagement Champion' and the 'Freedom to Speak Service'. She was advised Clare should call 111 or attend A&E if in crisis.

**14.35** The same member of staff told Clare of the action she had taken, Clare appeared to understand and remained in contact with them. Clare sent one message stating she had drunk alcohol every day in the last three years apart from eleven days and that Bob drank alcohol with her. These messages were not responded due to the member of staff being on holiday.

**14.36** Police found between January 2022 and the night of the murder multiple internet searches had taken place on the computer within the home (it was identified that Clare was the main user of the computer as Bob did not use IT equipment), the searches included:

- Domestic Abuse and Suicide.
- Sodium thiopental (a rapid onset short acting barbiturate general anaesthetic).
- Murders and capital punishment.
- Death row inmates.
- Fatal car crashes.
- Fatal car crashes where drivers were drunk under the influence.
- Deaths caught on camera/tape.
- Police shootings.
- Interviews with serial killers before execution.
- Alcohol intoxication.
- Mothers killing children.

## 15. Conclusion

**15.1** The tragic death of Bob has highlighted the complexities of abusive relationships especially where there is violence by both parties with addiction to alcohol. Bob has been unable to have a voice within this review, but we have made every attempt to ensure his voice has been heard throughout. Clare, by not taking part in the review, has had no input either. Little is known of the dynamics of the relationship or the true extent of the abuse however, with the bravery and honesty of Bob's family and Clare's colleagues, as well as the openness of those services who encountered the couple, the panel has utilised available information to seek learning and take forward recommendations for the future.

**15.2** When we consider Bob's loyalty to his marriage vows and his wife along with societal beliefs of 'how men should behave' it is not surprising he did not share what was happening within the relationship. Bob faced several possible intersectional barriers when considering speaking or seeking support, these barriers were:

- Being male.
- His belief system.
- Perception by Police as the perpetrator.
- Substance misuse.

**15.3** All these intersecting layers meant the abuse Bob was subjected to was not identified and he was never considered as a 'victim of domestic abuse', and although he was asked in interview about his relationship, no DASH RIC was completed after his disclosure. Clare was continually perceived as the victim no matter what disclosures were made.

**15.4** Kimberlee Crenshaw (who coined Intersectionality in the 1980's) states *'Without frames to allow us to see how social problems impact all the members of a targeted group many will fall through the cracks and suffer'*. Bob did not fit the 'frame' of services who were in contact with him and therefore he was never treated in the same way as a female victim.

**15.5** Whilst Clare was identified as the victim by Police and thought as a victim by her colleagues there was no consideration of her being the possible aggressor even with her admission and observations by Bobs' family, although we cannot be certain this could have been due to:

- Being a woman.
- Presenting as a victim.

- Role as a nurse.

**15.1** These different factors may have caused unconscious bias for those who encountered both Bob and Clare. We all need to be aware of unconscious bias, how it can impact the way we ask questions, how we can make assumptions especially when we think of who a 'typical victim and perpetrator' might be. At times due to these thought processes, we subconsciously avoid these conversations which can be detrimental in the offers of support and intervention. For practitioners, friends, families, and communities to overcome barriers in speaking to those who may be subjected to or using abusive behaviours any training and awareness needs to unravel and confront those unconscious bias's we all have.

**15.2** This review has highlighted that although Bob and Clare had contact with professionals and colleagues, details of any discussions was never recorded which has caused difficulty in understanding decision making and actions taken. It is essential those who are working frontline are confident in how to write their case notes as well as mechanisms to review staff notes and actions ensuring they are accurate, factual, and relevant. Even if conversations had happened with Clare to explore the risks and support options it is unlikely it would have changed her drinking habits outside of her working hours.

**15.3** To support practitioners with their awareness and confidence in asking questions there needs to be a package of different methods. For example, Bates found the use of pictures and images rather than 'traditional questions' with regards to exploring what was happening to men subjected to abuse as well as the impact, received a far more positive and engaged response. Therefore, how we ask men questions need to become routine but not the same as we use for women as the trauma and experience will be different. Bates found that only 4% of male victims had ever been asked by a professional if they were subjected to domestic abuse compared to the routine questioning of women. Asking questions about the relationship and injuries has been a reoccurring theme throughout this review and there were repeated missed opportunities for both Bob and Clare. We must remember even if those questions had been asked, both had capacity under the Care Act 2014[18] to make their own choices and decisions even if from the outside they appeared unsafe.

**15.4** Clare appears to have had a finality of thinking, she had told her colleague she wanted to kill herself and her internet searches were of either suicide or murder. Jayne Monkton-Smith discusses in her book 'In Control' and the Homicide Timeline – Stage 7 Planning, that planning is a contentious issue, because if we accept that killers plan murders it cannot be a crime of passion or a moment of losing control. Even though both were violent to each other, on the night of Bob's death Clare knew what action she was taking. There is the possibility she did not mean for him to lose his life when she stabbed him, however she stabbed him twice, would have known the risks she was taking and refused to treat his injuries whilst on the phone to the call handler. Her use of alcohol could be considered as an explanation for the murder, but as already noted in this review it does not cause someone to be abusive and is a contributing factor enabling someone to take risks they may not usually take.

[18] https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

**15.5** None of us know what conversations or actions happened between Bob and Clare that night or why she chose that evening to do what she did. What we do know is that Clare made the decision to stab Bob taking his life away when it was not her life to take.

## 16. Learning and Recommendations

**Learning Point 1**
There needs to be an increased awareness of domestic abuse including the additional barriers, complexities, and intersectionality victims (especially men) face when in an abusive relationship. This will enable communities and professionals the knowledge of how to offer a safe space to seek and offer help and support.

**Recommendation 1**
Develop a co-ordinated and multi-agency domestic abuse awareness campaign including male victims, and victims who have additional complexities such as mental health and substance misuse.

**Learning Point 2**
Health professionals are working under continued pressure with regards to their time and what support they can offer patients. Much of the population have a GP and although it is unlikely for a patient to make a direct disclosure of domestic abuse, ailments/injuries may be dealt with in isolation rather than to form a picture. It is therefore important all health professionals feel confident recognising possible signs of domestic abuse and how to approach victims and those using abusive behaviours.

**Recommendation 2**
All healthcare staff should receive additional training and resources to better recognise signs of domestic abuse especially with regards to male patients and those with additional complex needs. Any training should include the potential biases practitioners may have when recognising abuse with men compared to the recognition of abuse for women. Additionally, there needs to be an understanding of how male victims may present, and how their health concerns such as alcohol or mental health may be as a result of abuse within a relationship.

**Recommendation 3**
All GPs and practice staff (including receptionists) should have domestic abuse awareness training, to enable them to raise any concerns to the practice safeguarding lead for further risk assessment and appropriate action.

**Learning Point 3**
Given that domestic abuse and alcohol misuse was common knowledge by Clare's colleagues, the line manager could have triggered a more exploratory conversation with her. As part of the Trust's one to one supervision procedure, all employees are required to have a wellness plan in place which should be reviewed and where required updated during one-to-one support/supervision meetings. During these meetings managers should refer to the appropriate policy and procedure for guidance and seek HR support where applicable, for example the Domestic Abuse Toolkit and the Alcohol, Drug or Substance Misuse policy.

**Recommendation 4**
EPUT policies to be appropriately linked to the domestic abuse toolkit – including Employee Wellbeing sickness and absence policy, one to one support and appraisal policy.

**Recommendation 5**
EPUT to provide record keeping advice and guidance within the Domestic Abuse Training and Management Training.

**Recommendation 6**
EPUT Supervision Policy and template to add domestic abuse to any safeguarding concerns and how to escalate concerns and actions in supervision notes.

**Learning Point 4**
There continues to be sporadic involvement of statutory and non-statutory agencies at MARAC (and was also the case in 2016) this causes issues with relevant information sharing, highlighting risks and creating a SMART[19] action plan. There are no statutory requirements for agencies to attend or take actions, which is dangerous and a missed opportunity to share information and explore interventions for those involved.

**Recommendation 7**
MARAC to be given a statutory framework and requirement for agencies to attend and be proactive members of the discussions and action plans.

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[19] **S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**imely

**APPENDIX 1**

**Terms of reference**

The purpose of the review is to:

- Examine the events leading up to the incident, including a chronology of the events in question.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including challenging systemic issues and making changes to policies and procedures as appropriate.
- Improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

Key Issues:

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends, and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- Determine if there were any barriers Bob or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.
- Review agencies response, professional curiosity, interventions, care, and treatment and or support provided.
- Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards, domestic abuse and safeguarding policies, procedures and protocols and ensure adherence to national good practice.
- Determine whether workplace policies are inclusive and enable staff to raise concerns of colleagues where there is suspected domestic abuse (either as a victim or perpetrator).
- Review how organisations can empower employees to feel safe with disclosures of abuse, or concern of another whether in work or outside of the working arena.
- Review the communication between agencies, services, friends, family, and colleagues including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse for male victims.
- Is there a consistency in how agencies respond to victims of domestic abuse when both parties may present to an agency as a victim/perpetrator (possible "bi-directional abuse" and "counter-allegations"), is there any gender bias?
- Was there any impact of the Covid pandemic on those affected by or working with the family?