SETDAB | Southend, Essex & Thurrock Domestic Abuse Board

Southend Community Safety Partnership

Domestic Homicide Review

Executive Summary

Elaine

Died: July 2021

Chair and Overview Report Author: Cherryl Henry-Leach

Date: 07.07.2023

Final

Tributes to Elaine

“Elaine was a lovely kind-hearted, generous, loving and witty lady who can only be described as a bottle of champagne waiting to pop…

She will be sadly missed.”

Elaine’s son, Peter

Contents

1. Introduction

The panel formally expresses its sincerest condolences to the family and friends of Elaine[1].

The panel formally thanks Peter, who is also the son of Elaine and brother of the perpetrator for his contributions to this report.

2. Decision Making and Domestic Homicide Review Process

Throughout this report, the term domestic abuse is used interchangeably with domestic violence and the report uses the cross-government definition of domestic violence and abuse in line with the Domestic Abuse Act 2021[2].

This review has followed the 2016 statutory guidance for Domestic Homicide Reviews[3] issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. The statutory requirement to complete a Domestic Homicide Review rests with the Community Safety Partnership (CSP) for the area in which a domestic homicide takes place.

Essex Police, having due consideration to the definition of domestic homicide set out in section 1 of the 2004 Act[4] (see section 2), in line with locally agreed protocols, notified the Southend, Essex, and Thurrock (SET) Domestic Abuse (DA) Team very soon after Elaine's death and the perpetrator's arrest.

The SET Team then liaised with the Southend Community Safety Partnership. Agencies across Essex were asked to share any information they held in relation to Elaine and the perpetrator. An initial core group in early August 2021 was convened, where the known information was considered by agencies. At this meeting, it was agreed that in the absence of any safeguarding concerns being raised prior to Elaine's death, in relation to either Elaine or the perpetrator, the case did not meet the criteria for a Safeguarding Adults Review (SAR). It was also agreed that the case met the criteria for a Domestic Homicide Review and this review would explore, as part of its terms of reference, if there should have been involvement with Elaine and the perpetrator from Adult Social Care and/or Safeguarding.

The Police advised the panel that the family were extremely close-knit and neither Elaine nor the perpetrator had many close friends outside of the family home. The Police investigation did not identify any individuals outside of the family who could

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[1] The contributing family members have requested that the deceased is named as Elaine and other names have been changed in accordance with their wishes. They have requested the person responsible for Elaine's death is referred to "the perpetrator". As the perpetrator did not contribute to this review and so has not consented, this request has also been requested.

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[4] The Domestic Violence, Crime and Victims Act 2004. - GOV.UK (www.gov.uk)

give further insight as to the prevalence of domestic abuse within Elaine's relationship with the perpetrator.

The independent chair made contact with Elaine's surviving son, Peter. Contact was made initially through Essex Police, and he was offered the opportunity to participate in the Review in a way and at a time of his choosing. During each contact with Peter, the chair explored his support needs and although advocacy was offered, this was declined. When Peter's National Homicide Service Support Worker became ill, Peter decided not to receive further support but was fully aware of how he could self-refer into service if he chose to.

Peter had the opportunity to comment on the Terms of Reference for the Review and agreed to these. Peter confirmed that he was being supported and satisfied with the support he was receiving from his allocated National Homicide Service worker. Peter shared his shocked distress over the actions of his brother and advised that there was "no indication to Peter or Peter's partner that even suggested he was going to kill Mum." At the conclusion of the trial, attempts were made by the chair to reinitiate contact with Peter, following the Police advising this was in line with his wishes. Peter did respond and was given the opportunity to read and comment on the content of the draft report prior to publication. His contributions, feedback, and suggestions have been included where appropriate to do so within this report.

Given the devastating impact the murder of his mother by his brother had on him, which he described as being "overwhelming" at times, the chair is extremely grateful for the time and assistance extended by Peter in support of this review.

The perpetrator was written to by the independent chair, on behalf of the panel. In line with the 2016 guidance, he was invited to contribute to the review. He did not respond to this invitation.

On notification of the homicide, a total of 32 agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Elaine and the perpetrator. This enquiry established that no issues of domestic abuse were reported to Essex Police in relation to this family.

29 agencies returned a nil-contact, and after panel consideration, 1 IMR was commissioned from EPUT, and 6 summary reports were also provided. All reports included a chronology of agency involvement.

The chronologies were combined, and a narrative chronology was written by the Overview Report Writer.

The panel met a total of four times, with the first meeting of the panel on 19th October 2021. The final panel meeting was held on 22nd March 2023. There were delays that impacted on the completion of this review, namely the criminal justice process and the need to ensure Peter was enabled to fully reflect and provide meaningful comment on the report.

The chair wishes to thank everyone who contributed their time, patience, and cooperation to this review.

3. Contributors to the Review and Panel Members

The chair and author of this report, Cherryl Henry-Leach, is independent of all agencies involved and had no prior contact with any family members. She is an experienced DHR chair and holds the requisite skills as set out in the statutory guidance for the undertaking of Domestic Homicide Reviews[5]. This includes her experience in relation to domestic violence and abuse, having been active in this area of work for nearly three decades. These have included managerial roles at local, regional, and senior management/executive national levels in both the voluntary and statutory sector.

All panel members and IMR authors were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had had direct contact. Review panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

The panel membership was:

Name	Role	Agency
Lynn Scott Sarah Range	Head of Adult Social Care – Assessment and Wellbeing Head of Quality Practice & Principal Social Worker	Southend Council, Adult Social Care
Tendayi Musundire	Associate Director for Safeguarding	Essex Partnership University Trust (EPUT)
Sharon Connell	Head of Safeguarding	Southend Clinical Commissioning Group (CCG)
Michelle Williams	DA Coordinator	Southend, Essex & Thurrock Domestic Abuse Board
Simon Ford Gemma Robinson	Head of community safety Community Safety Data & Insights Analyst	Southend Community Safety Partnership

[5] Domestic homicide reviews: statutory guidance - GOV.UK (www.gov.uk)

Paul Hill	Business Manager	Southend Safeguarding Partnership (SSP)
Paul Hodson* Alice Faweya	Associate director for safeguarding MSE Named Nurse for Safeguarding Adults	Mid and South Essex NHS Foundation Trust (Southend Hospital)
Jules Bottazzi DI Ben Pedro Anido	Head of Strategic Vulnerability Centre Head of Operational Development Crime and Public Protection Command	Essex Police
Sarah Conlon	CEO	Safe Steps (DA Service)
Paula Blundell	Manager SEAS	South Essex Advocacy Service
Aliyah Monroe	Advanced Customer Support Senior Leader - Essex	Department for Work and Pensions (DWP)

* Since left organisation

4. Summary Chronology

In the early hours during the summer of 2021, neighbours were alerted to smoke coming from an address in a seaside town in Southend, Essex. The female occupant of the property, a ground-floor apartment, now known to be Elaine, could be heard shouting for her son, the perpetrator. The neighbour who resided above Elaine's home, evacuated the property and called the fire service. Whilst waiting for the fire service to attend, the neighbour attempted to gain entry into the apartment but were unable to gain access and rescue due to the volume of smoke. The fire service arrived soon after and rescued Elaine who required hospital admission. She died shortly after in hospital.

The perpetrator was later confirmed to be Elaine's son, who resided with her and was her main carer. CCTV in the area captured him leaving the property 80 seconds before the smoke was observed to be bellowing from the property. Essex Police located the perpetrator at the address of his friend and arrested him on suspicion of Elaine's murder and arson with intent to endanger life.

The panel also received confirmation from the Police that, during his trial, when the perpetrator returned to the family home, he told police officers at the scene of the fire that he had left the house to purchase a drink from a nearby fast-food establishment and, prior to leaving the home, had left a battery on charge in the hallway. Forensic assessments undertaken indicated that the perpetrator would have passed the seat of the fire and been aware of the fire being alight when he left the property. The Police investigation also established that the perpetrator undertook extensive internet searches to research the method of Elaine's death. During his trial, there was an

apparent indication that the perpetrator had a financial motivation when he murdered his mother. He also claimed that he was addicted to Codeine.

The sentencing judge did not accept this alleged addiction as mitigation and passed a life sentence for the murder of Elaine, with a minimum tariff of 27 years before he can be considered for parole. This reflected, in the Judge's view, the perpetrator's level of premeditation. He was also charged and sentenced to 8 years imprisonment for an offence of arson with intent to endanger life, which will run concurrently to the life sentence.

Peter advised the panel that Elaine was extremely supportive of both her children and their partners.

The perpetrator is a white British male who was aged 40 at the time of Elaine's murder. It is understood that he had been in a heterosexual relationship that broke down when he was aged 28 and, it was at this point in his life, he returned to the family home to reside with his mother. The panel understands that the perpetrator was in an intimate relationship with another male at the time of the murder. The panel found no evidence within the review that the perpetrator's sexual orientation was a contributing factor to the murder of Elaine. The perpetrator was not registered as having a disability, but the panel considered the perpetrator's diagnosis of back pain in relation to the Disability Discrimination Act (DDA). The perpetrator's inconsistent compliance with treatment made it challenging for the panel to fully understand his condition and to determine the impact it may have had on his situation and his decision to murder his mother.

Through the timeframe for the review, Elaine received clinical care and treatment in line with her age, health, and reduced mobility. The death of Elaine occurred during the period of national Covid 19 restrictions. The panel found that this did not impact on the care and treatment Elaine received.

The panel discussed concern that the perpetrator may have been taking Elaine's prescribed analgesia. The chair is grateful for the report provided by the Southend Clinical Commissioning Group which calculated Elaine's prescriptions received alongside dates these were requested This enabled the Police and the panel to be assured this concern was without finding, and the information was also shared with the criminal investigation team.

In line with the statutory guidance for the undertaking of such reviews, the chair attempted to invite the perpetrator to contribute to this review. At the time of authoring this report, he did not respond. The perpetrator has not given his consent to be referred to by name in this report and is referred to as "the perpetrator" throughout this report.

5. Conclusions

The limited evidence available to the panel did not enable it to identify what may need to change locally, and/or nationally, to prevent serious harm to victims of domestic abuse in similar circumstances. Based on the information shared with it, the panel did not identify any warning signs of serious risk leading up to the fatal incident resulting in Elaine's murder, that could reasonably have been identified, shared, and acted upon by professionals, including the use of markers/warning indicators within agency systems. The panel also did not identify any concerns raised by any agency or professionals that were not taken seriously or acted upon by others.

The panel established that fire safety checks are available to all homes in the area, and this is a free service.

The panel noted that research supported the learning point that it identified and, as this was addressed during the review period, it made no recommendation to address this learning.

The chair and panel extend its sincere condolences to Peter and others who knew Elaine and thank all who contributed to this review.

6. Lessons Identified and Recommendations

Learning point 1 – we need to ensure that practitioners are aware of the training available to them to enable their heightened awareness of domestic abuse perpetrated against older people and appropriate responses.

As this learning was immediately acted upon and progressed, with appropriate reassurance being received by the panel, the panel makes no recommendation.

The Home Office is invited to consider how the learning from this review could be shared with the Department for Work and Pensions and structured into any reviews or reforms of entitlement to Carer's Allowance.

Appendix 1 - Terms of Reference

The overall purpose of a domestic homicide review[6] 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 inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

Timescales for the Review

- Minimal agency involvement with either Elaine or the perpetrator was a feature of this case. To ensure a meaningful review that was proportionate to the known agency information, the timeframe for this review commenced on 1st January 2018 to the date of Elaine's death.
- Agencies with records prior to the start date above summarised their involvement. Any relevant information from agencies that fell outside the timeframe which has an impact or has the potential to have an impact on the key lines of enquiry is included.

Case Specific Terms

The panel also agreed the following case-specific terms to ensure a focused review:

1. To review if practitioners involved with the family were knowledgeable about potential indicators of domestic violence and/or abuse within familial relationships (i.e., non-intimate relationships), including coercive control, and aware of how to act on concerns about domestic violence and/or abuse.
2. To determine if appropriate consideration as to how accessible the support that was given by agencies involved with the family when making decisions in terms of the level and support provided to members of the family. This includes the family's capacity to understand those decisions and how they can respond to them.

[6] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

3. To establish if there were any opportunities for professionals to “routinely enquire” if domestic abuse, including coercive control, was being experienced by the victim that were missed, and if those enquiries would have recognised the victim's need for appropriate support, including being undertaken safely in line with best practice.
4. To establish how the impact of Covid affected this family specifically around isolation and access to services.
5. To establish the relationship between agencies regarding Elaine’s physical health and if she was receiving care that met her needs.
6. To establish if there was misuse of prescription medication in this case and if so, how can agencies manage the potential for misuse in the future.
7. To establish if there was appropriate information sharing between agencies in relation to any family members. If this did not happen what were the barriers or challenges for agencies?
8. To establish how professionals carried out assessments, including whether assessments and management plans in relation to any family member took account of any relevant history:
    - If any assessments could have afforded opportunities to assess risk.
    - Were there any warning signs of serious risk leading up to the incident in which the victim died, that could reasonably have been identified, shared, and acted upon by professionals, including the use of markers/warnings indicators within agency systems.
9. To establish if any agency or professionals consider that any concerns they may have raised were not taken seriously or acted upon by others.
10. To identify learning in relation to community awareness, including how community and/or faith groups and other potential access points for support, are supported to identify Safeguarding issues and/or victims of domestic abuse and share concerns with professionals, including if pathways for community and/or faith groups require development.
11. To review the appropriate use of legislation and relevant statutory guidance pertinent to the family’s situation.
12. To consider how issues of diversity and equality were considered in assessing and providing services to the family’s protected characteristics under the Equality Act 2010 – age, disability, race, religion or belief, sex, sexual orientation, gender reassignment, pregnancy and maternity, marriage or civil partnership. This will include consideration of how agency awareness and understanding of relevant cultural, race, religious, or nationality issues, and consideration of equality duties, impacted on responses and interventions.
13. To establish whether local safeguarding procedures were being properly followed, and how effectively local agencies and professionals worked together in relation to domestic abuse.
14. To establish if there are any issues locally affecting public confidence in the protection of people in vulnerable situations.
15. To identify any shared learning from ongoing domestic homicide reviews with similar emerging themes.

16. To identify any good practice and changes that may have already taken place.
17. Establish for consideration what may need to change locally, and/or nationally, to prevent serious harm to victims of domestic abuse in similar circumstances.
18. If neighbours, employers, work colleagues, community/family members, appear to have been aware of domestic abuse in the family – consideration to be given as to whether appropriate information is readily available to members of the public regarding the unacceptability of domestic abuse and how to seek help for someone.
19. Agencies completing IMRs will be required to analyse these issues in relation to their contact with Elaine and the perpetrator, 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.