Domestic Homicide Review
Executive Summary

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

Safer Chelmsford Community Safety Partnership

A Review into the death of Laura in February 2022

Independent Chair: Gary Goose MBE
Report Author: Christine Graham
January 2024

SETDAB Southend, Essex & Thurrock Domestic Abuse Board

Preface

The Safer Chelmsford Community Safety Partnership and it's Domestic Homicide Review Panel wish at the outset to express their deepest sympathy to Laura's family and friends. This review has been undertaken in order that lessons can be learned. We wish to place on record our thanks to the family for their engagement and challenge with the review; it has helped us form a deeper understanding of those involved and the issues they faced.

The review has been carried out 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 that ultimately culminated in Laura's murder in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by The Safer Chelmsford Community Safety Partnership on receiving notification of the death of Laura in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

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1. The Review Process

1.1 This summary outlines the process undertaken by the Safer Chelmsford Community Safety Partnership (CSP) Domestic Homicide Review Panel in reviewing the murder of Laura who was a temporary resident in their area. Laura was murdered in the February of 2022.

1.2 The pseudonym Laura has been used for the victim to protect her and her family's identity. The perpetrator will be known as 'Sam'.

1.3 Laura was only 19 years old when she was murdered by a man who she considered her boyfriend, Sam. She was a Canadian national who had met Sam online several years earlier whilst still a child. Sam was a 23-year-old local man. They had maintained an on-line relationship for around five years. This review has little doubt that she was the subject of grooming by Sam. Laura had travelled to the UK alone, only three months earlier, to meet him in person for the first time. They stayed at the flat he occupied in Essex.

1.4 On the day of her murder, police were called to the flat by friends of Laura who were unable to contact her. Her deceased body was found on the bed with multiple injuries and Sam was present at the address. A subsequent post-mortem identified that she had been strangled and then stabbed multiple times.

1.5 Sam was arrested at the scene and subsequently charged with her murder. He pleaded guilty to the murder and, in October 2022, was sentenced to life imprisonment. He is required to serve a minimum of 23 years 6 months before being entitled to be considered for parole.

1.6 Sam had an extensive criminal background. In sentencing him, the Judge noted:

'You have eight previous convictions for 12 offences, almost all of your offending history involving domestic violence, including assault, harassment and criminal damage against your mother and against former female partners or breaches of restraining orders and suspended sentence orders made as a result of your prior convictions for domestic violence and harassment. Your criminal record in other words shows a clear history of violent and controlling behaviour towards a number of women beginning from your mid-teens onwards.'

1.7 Whilst Sam made no comment to police in any interviews after his arrest, he has engaged with this review.

1.8 A number of agencies had been involved with Sam since childhood and have a significant amount of recorded contact. This review has considered that information, and in addition, any information known about his relationship with Laura prior to her visiting the UK and during the time they spent together before her murder.

1.9 The CSP was notified of the death within a week of its occurrence. This demonstrated a good understanding by the police of the need for a referral at the earliest possible opportunity.

1.10 Thereafter, a core group meeting of the Southend, Essex and Thurrock Domestic Abuse Partnership Board was held on 1st March. At this meeting the police provided a summary of the incident, and agencies provided an overview of historic contact from their records. The meeting agreed unanimously that the criteria had been met and that a Domestic Homicide Review would be undertaken. The process in place within Essex ensures that at the point

that agencies are notified that a DHR is being considered, they are asked to secure all the records in readiness for any such process that follows. The Home Office were informed of the decision.

1.11 Gary Goose MBE and Christine Graham were appointed to carry out the review in the roles of Independent Chair and Independent Report Author. An initial meeting was held between the Chair and the police to ensure that Section 9 of the statutory guidance was adhered to in relation to disclosure and criminal proceedings was taken into consideration. As a result of guidance from the police and the CPS, the review continued in limited scope until the issues in any forthcoming criminal process were resolved.

1.12 An Independent Mental Health Review into the care and treatment of Sam was also commissioned by NHS England. Agreement was reached that the two processes would run alongside each other, and the mental health investigator became a valuable member of the DHR Panel. To reduce the burden on the families involved, interviews with Sam, and Sam's family were carried out jointly between the Independent Chair and the mental health investigator.

2. Contributors to the Review

2.1 A large number of agencies contributed to the Review.

2.2 An initial chronology was prepared with the information known by the different agencies and subsequently written information was commissioned from:

Individual Management Reviews

- Chelmer Housing Partnership
- Essex Partnership University NHS Foundation Trust (EPUT)
- Essex Police
- North East London Foundation Trust (NELFT)

Summary Reports and additional information

- Chelmsford City Council – Housing
- Department for Work and Pensions
- East of England Ambulance Service
- Essex County Council - Children's Social Care
- Essex Wellbeing Service – Provide
- Multi-Agency Risk Assessment Conference (MARAC)
- Phoenix Futures
- Probation Service
- Essex Youth Justice Service and Youth Offending Team

2.3 The review panel confirmed that each of the IMR/Summary reports were independently authored and had appropriate organisational governance approval.

3. The Review Panel

3.1 The review panel met a number of times, and the review panel agreed a draft overview report and the reviews concluded in March 2024.

3.2 The members of the Review Panel were:

Gary Goose	Independent Chair	
Christine Graham	Independent Report Author	
Tracey Spencer	Director	Chelmer Housing Partnership
Spencer Clarke	Public Protection Manager	Chelmsford City Council
Kaylie Charlery	Senior Community Safety Officer	Chelmsford Community Safety Partnership
Louise McSpadden	Service Manager	Essex Safeguarding Children Board
Tendayi Musundrie	Head of Safeguarding	Essex Partnership University NHS Foundation Trust
Matt Cornish	Domestic Abuse Superintendent	Essex Police
Ben Pedro-Anido	Detective Sergeant	Essex Police
Jules Bottazzi	Head of Strategic Centre Crime and Public Protection	Essex Police
Ruma Saha Stephens	Service Manager	Mid Essex Children's Social Care
Cheryl Gerrard	Associate Designated Nurse, Safeguarding	Mid Essex Integrated Care Board
Jay Brown	Named Nurse for Safeguarding Children	NELFT
Bev Jones	Chief Executive	Next Chapter[1]
Carol Rooney	Specialist Mental Health Practitioner	Niche Consulting
David Messam	Head of Probation Delivery Unit -Essex North	Probation Service
Emma Tulip-Betts	Specialist Wellbeing & Public Health Officer	SETDAB
Tasmin Brindley	Domestic Abuse Support Officer	SETDAB

3.3 It was not possible to complete the review within the six months set out within the Home Office Statutory Guidance for the following reasons:

- The review could only proceed in limited scope until the conclusion of the criminal trial.
- The complexity of the case, and the number of agencies involved, meant more time was taken.

4. Involvement of Laura's family and others to assist the review

4.1 The Review sought to engage with Laura's family who are resident in Canada. Laura's mother agreed to a virtual interview with the Chair and Author. Attempts were made to speak with other members of Laura's family, but this was unsuccessful.

[1] Specialist domestic abuse service

4.2 Sam's mother and stepfather were interviewed jointly by the independent chair and the mental health investigator.

4.3 Sam engaged with the review and was interviewed in prison by the independent chair and the mental health investigator.

5. Domestic Homicide Review Chair and Overview Report Author

5.1 Christine Graham undertook the role of Overview Author on this Review. She previously worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

5.2 Gary Goose undertook the role of Independent Chair on this Review. He had previously served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector: his policing career concluded in 2011. During this time, as well as leading high- profile investigations, Gary led the police response to the families of the Soham murder victims. From 2011, Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility as well as substance misuse and housing services. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

5.3 Christine and Gary have completed, or are currently engaged upon, a number of Domestic Homicide Reviews across the country in the capacity of Chair and Overview Author. Previous Domestic Homicide Reviews have included a variety of different scenarios: male victims; suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim; and reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the Independent Office for Police Conduct (IOPC), NHS England and Adult Care Reviews.

5.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[2]

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

6. Terms of Reference

SAFER CHELMSFORD COMMUNITY SAFETY PARTNERSHIP

Terms of reference for the Domestic Homicide Review into the death of Laura

6.1 **INTRODUCTION**

6.1.1 This Domestic Homicide Review (DHR) is commissioned by Safer Chelmsford Community Safety Partnership in response to the death of Laura which occurred early in 2022, for which her partner, Sam, has been charged with murder.

6.1.2 The review is commissioned in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004.

6.1.3 The chair of the partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Independent Report Author for the purpose of this review. Neither Christine Graham or Gary Goose is employed by, nor is otherwise directly associated with any of the statutory or voluntary agencies involved in the review.

6.2 **PURPOSE OF THE REVIEW**

The purpose of the review is to:

6.2.1 Establish the facts that led to the incident early in 2022 and whether there are any lessons to be learned from the case about the way in which professionals and agencies worked together to safeguard Laura.

6.2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

6.2.3 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

6.2.4 Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

6.2.5 Contribute to the understanding of the nature of domestic abuse.

6.3 **THE REVIEW PROCESS**

6.3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

6.3.2 This review will be cognisant of, and consult with, the criminal investigation into Laura's death and the process of inquest held by HM Coroner.

6.3.3 This review will liaise with other parallel processes that are ongoing or imminent in relation to the incident in order that there is appropriate sharing of learning.

6.3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for the criminal and coroner's courts.

6.4 **SCOPE OF THE REVIEW**

The review will:

6.4.1 Draw up a chronology of the involvement of agencies involved in the lives of Laura and Sam to determine where further information is necessary. Where this the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of the Act.

6.4.2 Produce IMRs for the time period from 1st January 2015 to the date of the homicide.

6.4.3 Invite responses from other relevant agencies, groups or individuals identified through the process of the review.

6.4.4 Seek to understand Laura's life and her move to the United Kingdom to be with Sam.

6.4.5 Explore Sam's life and his previous domestic abuse offending.

6.4.6 Explore this brief relationship against the Homicide Timeline as set out by Professor Jane Monckton Smith to understand the path that this relationship took.

6.4.7 Understand the interaction that Sam had with mental health services.

6.5 **FAMILY INVOLVEMENT**

6.5.1 The review will seek to involve Laura's family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

6.5.2 We will seek to agree a communication strategy that keeps families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

6.5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of stress and anxiety.

6.6 **INVOLVEMENT OF THE PERPETRATOR AND HIS FAMILY**

6.6.1 The Chair and Report Author will seek to meet with the perpetrator and his family to understand their perspective on Sam's life and what led to the incident.

6.7 **THE OVERVIEW REPORT**

6.7.1 The review will produce a report that summarises the chronology of events, including the actions of involved agencies, analysis and comment on the actions taken. The report will make any required recommendations regarding safeguarding of individuals where domestic abuse is a feature.

6.7.2 Aim to produce a report within the timescales suggested in the Statutory Guidance subject to:

- Guidance from the police as to any sub-judice issues
- Sensitivity in relation to concerns of the family, particularly in relation to parallel enquiries, the inquest process, and emerging issues

6.8 **LEGAL ADVICE AND COSTS**

6.8.1 Each statutory agency will be expected to inform their legal departments that the review is taking place. The costs of legal advice and involvement of their legal teams is at their discretion.

6.8.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then Safer Chelmsford Community Safety Partnership will be the first point of contact.

6.9 **MEDIA AND COMMUNICATIONS**

6.9.1 The management all media and communications matters will be through the Review Panel, escalating to the CSP chair as necessary.

7. Summary Chronology

7.1 This section will summarise what was known to agencies about both Laura and Sam's background. This will set the context for both.

7.2 The review looks in more detail at what is known specifically about how their contact began and how their online relationship grew to the point where Laura came to the UK specifically to meet Sam in November 2021. It will detail what professionals knew about that contact in full within the main report.

7.3 This review is focused upon the murder of Laura, however, in order to properly learn lessons, the review has looked at what is known about any of Sam's previous relationships, his behaviour towards previous partners and his family, and what agencies knew about that behaviour.

7.4 Whilst this review is aware of each of the previous interactions it has sought to summarise most of them rather than include the detail within this report. To include such detail have

the capacity to detract from Laura as the victim and potentially put other previous victims at risk of retrauma.

7.5 The review has however, made specific note of issues and evidence that was available to show the risk that he posed to potential victims and in particular to Laura.

7.6 **Laura**

7.7 Laura was a Canadian national and was 19 years old at the time of her death. Her family have paid tribute to her, describing her as a 'go-getter', who did what she wanted, when she wanted, and who was extremely successful at anything she put her mind to.

7.8 They have said she was extremely witty and was kind, spending any money that she made on her niece. Whilst at school she went out of her way to help other students who were not comfortable in the school and to support them. She didn't take any nonsense from anyone – she had no place in her life for people who were rude. If someone 'sassed' her, she wouldn't stand for it. She was very principled and had her own set of standards – she would pull people up on poor behaviour. If she saw something unjust, she would step in and say something. Laura kept busy between school, sports and working.

7.9 She was a loyal friend, sibling and daughter and fiercely protective of those she loved. She played many sports including, ringette, dance, soccer, tennis, cheer and skiing. Her dream was always to go to England as she was always loved to travel. According to her mother, staying in their small town in Canada was never an option for her once she turned 19.

7.10 Laura lived with her family in Canada and during her teen years she had moved between her mother's home and her father's house, spending significant periods with both. In late 2020, early 2021, Laura became attracted to a religion; she joined the Church of Latter-Day Saints and was baptised. After this she regularly attended services.

7.11 Whilst growing up her family say Laura did not have any serious relationships with boys, but they were aware she had been in online contact with Sam for a number of years. It is now clear to this review that Sam and Laura first began speaking with each other online when she was 12 or 13 years old, at the time Sam was 15 or 16 years old. We also now know that whilst some services became aware of their contact, and concerns were raised by staff, neither her name nor her age were identified at this time. This is a particular area of concern for this review and we address this later within this report.

7.12 Laura was private about this online 'relationship' with neither her father nor her stepmother knowing much about Sam. Laura however was close to her sister, and it is known through her that within the online relationship there were some arguments, leading to periods when Laura and Sam did not talk.

7.13 Laura's mother says that when she was 16 she asked to go and visit Sam, her mother refused. However, by 19 she was an adult and saved money to fly to England.

7.14 She says that as she knew that Sam had a mother and sister who he was close to, she felt safer about her travelling to England. She understood that Sam and his mother were very excited to have Laura come and even bought her stuff ahead of time as she heard his mother tell Laura all about it. This eased their minds and they thought if it did not work out between

them then she could come home and at least move on from him and get him out of her mind.

7.15 Laura's mother also says that she had spoken to Sam via facetime and he assured her that Laura would be safe with him and he would 'protect her with his life'. Eventually Laura's mother gave her her blessing and told her to have fun and explore England and keep in contact along the way. Once in England she took photos and sent them to her mother and she was in contact with her sister and mother all the time. She understands them to have had an instant connection and things were going great until late December when he had been admitted to the hospital thanks to Laura calling ambulance. When her mother heard of this she called her and urged her to come home, but Laura insisted that she loved him and wanted to help him any way she could. Her helping nature and love for him would ultimately cost her, her life.

7.16 Laura's family believe that Sam had some kind of emotional hold over her as she was ordinarily strong and would otherwise have packed her bags and left the UK. **All the information gathered by this review provides a clear indication that the correct terminology for the 'relationship' between Sam and Laura, was that she was the victim of grooming by Sam.**

7.17 **Sam**

7.18 Sam was the third child to his parents. Information available to this review suggests that his father appeared to state during the pregnancy that he would leave if his mother had a third child, and it was when Sam was about 6 weeks old that he left.

7.19 Around the time of the separation, Sam's mother lost the support of her family and the Jehovah's Witness community, a faith she had been raised in. This has been described being caused as they did not agree to her separation, and she felt she had to leave the faith.

7.20 Sam's paternal grandparents have both been described as having mental ill health problems, for Sam's paternal grandfather this was undefined, and his grandmother apparently had psychotic episodes and had bipolar disorder, she died in 2012. It is unclear what support the paternal family have provided to Sam and his family.

7.21 As a result of information known to this review it is clear that Sam grew up with the knowledge that when his mother became pregnant with him, his father told his mother that he did not want another child and if mother wanted to keep the baby, then he would leave.

7.22 The quality of Sam's father's relationship throughout Sam's childhood is unclear, as is the level of contact that they had. The review has been told that his father could often let him down and this was a source of frustration and anger for Sam.

7.23 Sam's mother had another significant relationship with a new partner; however, she told professionals that she moved to get away from him in around 2013 and she later described problems that were caused when her by then ex-partner was still in contact with Sam against her wishes.

7.24 Sam's mother said that when Sam reached 14 it was as though a 'switch had been flipped'. He began to have what she described as intrusive thoughts; those thoughts being that he wanted to kill his mother by stabbing her in her bed at night. They moved house. Sam

moved schools for a fresh start. She said that he lasted at the school (details of which are known to the review) only a matter of six weeks when the school excluded him saying that 'he didn't fit in'. Thereafter he went to a pupil referral unit. Essex Children's Social Care (ECSC) became involved (Sam's mothers make the point that the support that Sam and they got was much better when he was a child than when he moved to being an adult).

7.25 Sam's mother and stepfather said that they lost count of the number of times that Sam wrecked the house. They say that the police were called 2-3 times a week when it was at its worst. They say that they were told that often the police could not do anything if mother called saying he was about to 'kick off' – because he had not done anything. She said a flag was on police systems because of the calls and that the youth offending and then probation services also became involved with him.

7.26 When Sam was 18, he moved out of home and into supported living.

7.27 Sam's mother's information provides some of the background to Sam. The following summarises what is recorded within agency records.

7.28 **Children's Social Care (ECSC)** first became involved with the family in July 1999. This was not in relation to Sam or any impact upon him however it is included as this is the first mention of Sam's family in ECSC records.

7.29 By December 2014 Sam was not attending school regularly and was eventually excluded as he would often make female students feel uncomfortable.

7.30 Sam breached the restraining order by contacting a previous girlfriend in December 2014.

7.31 The key issues in Sam's involvement with ECSC were considered as follows:

- Multiple incidents of violence and aggression within the family home directed at mother and sister.
- Described as needing anger management/counselling from the age of 11.
- Worked with CAMHS for 3 years from the age of 11.
- Presented with low self-esteem and confidence and rarely left the home without an adult.
- Poor social skills in real life and being 'boss' in virtual friendships.
- Medicated for anxiety and depression.
- Struggled to self-regulate and had little resilience when upset.
- Described with varying domestically abusive behaviours including coercive and controlling behaviours.
- Not consistently compliant with medication – on some occasions he complained of side effects, but on other occasions, his mother thought it was deliberate to 'punish' her. His behaviour generally worsened after about three days being non-compliant.
- He refused to go to school so always at home and mother had little reprieve although father sometimes provided respite.
- His attachment and anxiety when separated from mother was commented on.
- He had plenty of free time which seemed to allow his intrusive thoughts time and space.
- Preoccupied with internet access and was described as somewhat obsessive.

- Mother seemed unable to impose rules and boundaries consistently and she regularly expressed her fear of him, which was not without merit given his expressed thoughts of murdering her, his threats with weapons and his escalation over minor things.
- Sam showed no remorse and could not think about his impact on others.
- Considered to possibly have traits of autism, but other professionals concluded that he was not autistic.
- Sam was later identified to have some learning difficulties, but it was not clear what the impact was on him.
- The file alludes to a history of domestically abusive relationship between his parents, but there is little detail of this.
- Sam was witness of the abusive relationship of his mother's ex-partner who then seems to manipulate Sam when he was having unauthorised contact.
- He was witness to the violence and aggression of his older brother during the periods that he came to stay with the family (his brother lived with his father).

7.32 Sam's involvement with mental health services (provided by **Essex Partnership University NHS Foundation Trust – EPUT**) started late in 2014, when he was 15 years old, following a referral from his GP who was concerned about Sam's frequent incidents of violence, anger, and self-harm. It appears that his anger management issues extended beyond the family home, and he was, at the time, educated at a Pupil Referral Unit because of his aggression towards teachers.

7.33 While Sam waited for a CAMHS[3] assessment, he was issued with a restraining order after a conviction for the harassment of a 15-year-old girl. He was also arrested for assaulting his mother and causing damage to the family home. He was assessed by CAMHS and the Youth Offending Team (YOT) for probation.

7.34 The risks identified were the potential to cause harm to animals, anger outbursts and his negative attitude toward females. Sam initially described hearing voices but was not thought to be psychotic after an assessment by the early intervention in psychosis team (EIPT). He was seen regularly for CAMHS psychiatry reviews and was allocated a key worker.

7.35 When Sam turned 18 in 2017, he was referred to EPUT's adult secondary mental health service. He continued to be aggressive to his mother and destructive in the home. He also began to display aggressive thoughts towards others, self-harm and further escalation of his illegal drug use.

7.36 **Essex Police** have numerous incidents and intelligence relating to Sam beginning in 2003. The concerns identified include:

- Significant repeated mental health concerns over a number of years including suicide attempts.
- Thoughts on harming animals and admitting abuse to animals.
- Reference to domestic abuse within the family whilst Sam was a young child.
- Numerous domestic abuse incidents towards partners and his family, including:
- Stalking & harassment to partners.
- Breach of order(s) (restraining/non-molestation) relating to partners.
- Battery, sexual offences, threats to kill, controlling coercive behaviour.
- Destroy or damage to property/ criminal damage.

[3] Child and Adolescent Mental Health Services

- Malicious communications.
- Allegations of rape.
- A number of custodial sentences.
- Substance misuse (cannabis, crack/heroin, cocaine).
- Child Sexual Exploitation (CSE) concerns (as victim).
- Perpetrator of anti-social behaviour.

7.37 The police did not identify Laura specifically until after she had arrived in the UK to meet Sam towards the end of 2021. At that point they attended following a report by her of a burglary at Sam's address after she come to the UK November 2021. However, police and ECSC both had information about Sam being obsessed with a girl called 'Laura' from Canada first in 2016. The 'girl called Laura' was recognised as a child at risk of sexual exploitation at the time but for a variety of reasons she was not identified, and no contact was made with her or her family. This is obviously a central issue for this review and Section 8 of this review deals with this issue in more depth.

7.38 The review has had sight of all calls made in relation to Sam's behaviour. It clearly shows the historic behaviour of Sam resulting in a number of arrests and restraining orders from the Court for different partners. Many of these incidents occurred whilst he was in on-line contact with Laura.

7.39 Two of the primary victims of Sam's abuse were his mother and sister. His mother was identified as high-risk victim and referred to MARAC because of the threat he posed.

7.40 Between 2015-2019, police attended the family home on at least 25 occasions as a result of calls from his family for help.

7.41 Sam was also arrested 19 times in this period for a variety of offences and all were abuse related. The victims were either partners or his mother and sister. The offences included assault, damage, threats, harassment, breaches of restraining orders and making and distributing sexually explicit images of ex-partners. These incidents are looked at in more depth later within this report.

7.42 Sam was known to **NELFT Psychiatry and Youth Offending Team within the Emotional Wellbeing Mental Health Service** between February 2015 and April 2017. He was discharged to the adult mental health team when he turned 18.

7.43 Sam was known to **Provide (Essex Wellbeing Service)** in 2014 and 2015. He was open to Community Paediatricians for an Autism Diagnostic Observation Schedule (ADOS) assessment which found no evidence of autistic spectrum disorder. He had a history of behaviour difficulties and was attending alternative provision (Pupil Referral Unit). He presented with low self-esteem and that he had learning difficulty which could lead to frustration, anger, and behavioural difficulties. The family were having support from Family Solutions at the time. It was recommended that his cognitive and learning ability were formally assessed, that he received support for his self-esteem and motivation and his mother was given information on Families in Focus.

7.44 Sam was a Looked After Child following a domestic abuse incident and a request was sent for an Initial Health Assessment with Community Paediatricians, but he returned home after two days so the IHA was not completed.

7.45 There is information to show that as he neared his 18th birthday Children's Social Care took the case to the transitions panel, there is though no record of any subsequent adult social care involvement with Sam.

7.46 The review has sought to identify Sam's relationship history and it is clear that he was abusive to almost all of previous partners. Some of this was known to professionals but much of it was not.

7.47 The review can say that contact between Laura and Sam is likely to have begun in 2015 when they met online. Professionals became aware of it during 2016 and concerns were raised by staff from the youth offending team and a social worker. The concerns arose out of his behaviour towards a previous girlfriend, where he was obsessive, convicted of harassment and had received a restraining order that he breached on multiple occasions.

7.48 The full report details what was known and what was done to identify Laura at that time. We can say, that although she was known about, and rightly identified as a child who was at risk of exploitation, **she was not identified**. We make recommendations in relation to this aspect.

7.49 Sam and Laura maintained online contact from 2015/16 to the point where Laura made the decision to come and stay with him in the UK. Those organisations who had previously known about a 'Laura' did not record any information to suggest that the relationship was continuing.

7.50 During the intervening years, Sam embarked upon a number of relationships. The vast majority of these were abusive. He continued to abuse his own mother and sister. As a result, he spent time in prison for assault and for breaches of restraining orders. He also spent time in psychiatric care because of significant episodes of self-harm. It is unclear how much of this Laura knew. Sam says she knew some of it but not all.

7.51 Sam's mother witnessed, and was victim of, Sam's behaviour for many years. She also knew how he behaved towards his girlfriends. She says that when she heard Laura was going to come to the UK, she was concerned and told her that she shouldn't come because of his state of mind at that time.

7.52 Laura came to the UK in November 2021 solely to meet and stay with Sam. In December Sam self-harmed and this resulted in a stay in hospital. Laura told medical staff that she would look after him when he was discharged.

7.53 It is clear that Sam abused Laura whilst she was in the UK and that by the end of January/early February she was making plans to return to her home in Canada. This seems to have prompted Sam into first seriously assaulting her on the morning of her death. The assault caused Laura to leave the flat and go to a neighbour. She was persuaded to return by Sam. It was then that he killed her.

7.54 Sam was a young man who was obsessed, controlling and jealous in all his relationships. He says himself that when he had had enough of a girlfriend, he would act in such a way as to cause them to leave, he felt he could then blame them and not himself for the breakup. In Laura's case he says when she had decided to leave, extreme jealousy affected his thoughts, and he killed her.

7.55 There is no evidence that Laura had any knowledge of the UK's Domestic Violence Disclosure Scheme, and there is no evidence that the police recognised that Sam was someone whose partners should attract proactive disclosure.

7.56 Sam was not recognised by police for the true risk that he posed. Much of this was because of a reliance upon a risk matrix that focused upon frequency rather than better indicators of risk, such as the nature of behaviour towards victims.

7.57 The review makes recommendations in relation to these areas as the following sections will show.

8. Key issues arising from the Review and Lessons Identified

8.1 In this section the review will consolidate the key issues for this review - the elements from which services can learn and any positive areas of practice.

8.2 **Identifying any trail of abuse**

8.3 Every Domestic Homicide Review should look to identify any tail of abuse within the relationship.

8.4 In this case, that trail of abuse is clearly evident both in Sam's abuse of Laura and also in his abuse of almost every woman or girl that he formed a relationship with, including significant levels of abuse towards his mother and sister.

8.5 This review has set out the consistent levels of abuse that Sam imposed upon his victims. That abuse was both violent and non-violent. It spread across almost of all the constituent parts of the definition of domestic abuse and, alarmingly, was recorded and recognised across a range of agencies.

8.6 The review has looked at the level of risk he posed and why it and he did not attract a greater level of pro-active preventative work. This will be commented upon that further within this section.

8.7 The review has the benefit of learning from Sam himself about his attitudes to women and girls, and the dangers of obsessive behaviour.

8.8 Sam's identified trail of abusive behaviour towards others appears to begin to develop into levels of real concern when he was in his mid-teens.

8.9 At the age of 15 Sam was obsessed by a 14-year-old girl (Female A) who he considered to be his girlfriend and travelled from Essex to Wales to be with her. He subjected her to physical violence and to a campaign of vile harassment and threats. The harassment included the threat of using sexually explicit photographs and continued persistent attempts to contact her. In short, he would not accept 'it was over'.

8.10 Sam's level of harassment was such that he was arrested and charged with offences. At 15 years of age, other forms of diversion from the criminal justice system would have been considered, but his threat was such that placing him before the court was considered the right course of action. Thereafter, he breached restraining orders placed upon him regularly, attempted to use deceptive ways of getting in contact and ultimately ended up in prison

because of his lack of adherence to efforts to protect the girl from him. That level of obsessive behaviour became a source of real concern for some professionals when he was identified as first being in contact with Laura when she was only 13 or 14 years old. But as will have been seen within this report, she was never identified and thus no warnings were given to her or her parents about Sam's behaviour.

8.11 Sam himself, says he did not recognise the dangers of that level of obsessive behaviour at the time and now does. He says he wants others to recognise it and to learn from it.

8.12 Despite his supposed level of obsession with both Female A, and subsequently Laura, he went onto have multiple relationships with other women as he grew. Each relationship appears characterised by abuse, Sam becoming completely controlling over them before it ended in violence with threats of exposing sexually explicit images, threats to kill or injure and high levels of coercive behaviour by Sam's extreme self-harm.

8.13 Sam now accepts this was a regular pattern. He would engineer a situation where, when he tired of a partner, he would behave so abusively that he would cause her to end the relationship. He could then blame her for ending things and have 'his conscience clear'. This is a real demonstration of some of the worst excesses of that type of behaviour. This was exactly the same in the case of Laura. This review has little doubt that he subjected her to significant levels of abuse. She must have been terrified during the last day of her life when he assaulted her, coerced her back to his flat out of fear and then killed her.

8.14 His behaviour is also a demonstration of a lack of respect for women. That level of misogyny is dangerous at any level. Any woman with whom he became involved was thus at risk of real danger and why that was not always recognised is something that is central to this review.

8.15 His behaviour towards his own mother and sister was equally extreme. His mother found herself in an almost impossible situation. His behaviour towards her was so extreme and threatening that both she and her daughter fitted locks to their bedrooms for fear of attack at night. Sam had visualised and verbalised his visions of killing his mother and sister. He repeated these at times to professionals working with him. Yet, he was still her son, whom she loved. He was a desperate young man who self-harmed and went from rage to despair in seconds. Sam was often described as being calm when police and others attended, thus mitigating any action to follow. His mother only ever wanted to do what was best for him and thus tolerated the attacks, threats and damage time after time.

8.16 Despite not being able to mount prosecutions for many of his behaviours towards his mother, she was identified as a high-risk victim of Sam and work was done to try and mitigate his threat towards her.

8.17 **Laura - What was done to identify her as a child at risk of exploitation by Sam?**

8.18 Sam first became involved in on-line chats with Laura when she was only 13 years old, and he was 16 nearly 17. The power dynamic that exists in that age gap at those early years is obvious. He quickly became equally obsessed with her and the danger of that was recognised when a member of the Youth Offending Team and a social worker involved with him became aware of the contact. They reported their concerns via a safeguarding notification to the police and what happened to identify Laura is recorded earlier within this report. Records show that it was intended that efforts should have been made to identify

her and that consideration was given to a variety of tactics to gather that information. There were, however real issues with how, practically this would be done at that time. She was, ultimately, not identified and records relating to her became less and less visible as time went on.

8.19 To take a view that nothing was done would be wrong. There was clearly a view that he did present a danger to himself and others. Once the information had been shared, there were attempts made to obtain more information from him about Laura and his views towards her.

8.20 He was resistant to providing information and lied about her age. Once it was clear that he was not going to provide the information, there were only really two options:

- Use subterfuge or secrecy to try and get the information without Sam's knowledge, or
- Obtain some form of order to access the computer and ascertain the information in that way.

8.21 The avenue of using subterfuge to obtain the information was really only available if Sam's mother or sister were to be used as the source of the information. Given the nature of his appalling behaviour towards both, this would have put them at a significantly increased risk of serious harm, or worse, had he found out. It must not be forgotten that he had told them how he would kill them, he assaulted them, damaged property, and had caused them to fit internal locks to their bedroom doors to protect themselves. Therefore, this review fully understands the reasons not to use that route.

8.22 Turning then to other forms of orders or interventions. In their reflective assessment following Laura's death, the police themselves have said that: 'the primary objective should have been to identify the child at risk and then instigate whatever safeguarding actions were possible through Interpol and the Canadian authorities. However, this objective does not appear to have been recognised, it was certainly not articulated or progressed.'

8.23 Whilst the review agrees that identification of Laura should have been a priority, after all she was at that time an unidentified subject of a CSE referral, it remains difficult to consider any practical steps that could have been taken to further identify her. The police were keen to identify her: that is clear from the actions that are recorded in their records. However, whilst those considerations were ongoing, Sam informed a Child in Need meeting that the relationship was over; therefore, the records were closed.

8.24 The police were not informed, nor did they consider the fact, that the relationship had restarted less than a month later. They should have been told about the information stating that the relationship had restarted. It was the fact that the relationship was believed to have ended – together with the physical distance between Laura and Sam, the fact that she was only 14 years old, and that she did not have the means to get to the UK – which all meant that further considerations and a more imaginative approach to identify her was not taken. She did not appear again in any other record relating to Sam until she had arrived here.

8.25 The dangers of not identifying a child who had been recognised as at risk of exploitation are clearly set out within this review. Changes have been recommended as a result.

8.26 This review has no hesitation in describing Sam's behaviour towards Laura as being one of grooming. He became obsessed with contact with her. At times, threatened and verbally abused her, but also made her aware of his self-harm and 'his problems'. He made her feel

responsible for him, preying on her caring nature. He created a situation where she wanted to 'save him', thus coming to the UK to meet up with him. Once here, the relationship developed in the same way as each of his others. Sam explained to this review why he killed her instead of just allowing her to leave and then blaming her like he did all the others. His explanation is just one of pure jealousy and selfishness.

8.27 **The recognition of Sam's risk**

8.28 As soon as Laura's murder was discovered and Sam's history emerged, Essex Police undertook an immediate review to try and understand and learn from why he was not a person who was subject to much greater police scrutiny. That review is referenced within this report, and it is the police's view that the then accepted risk matrix used (the RFG matrix) did not sufficiently highlight Sam's true risk. It is clear that it did not. The review does, however, recognise this immediate review as an example of positive practice.

8.29 The work done by Essex Police to develop a risk matrix that builds on RFG and includes other factors that could be considered a far greater insight into proper risk, such as controlling and coercive behaviour, harassment campaigns etc, seems a significant step in progressing risk assessments. The fact that had the newly developed risk framework been in place at the time, then Sam would have been amongst the top 10 potential offenders subject to far greater scrutiny and proactive intelligence gathering and preventative work. The review endorses the police's efforts to better understand offending behaviour and thus better protect potential victims in the future.

8.30 Having said all the above the review does consider that there were a number of missed opportunities to intervene more effectively with other victims before Laura. There is no evidence that DVDS was utilised or considered for other victims despite Sam's recorded behaviour. There were also opportunities for better liaison between police forces that led to at least one victim not feeling supported enough to progress her allegations against him. Both these issues are considered significant issues for this review.

8.31 **Knowledge and use of the Domestic Violence Disclosure Scheme (DVDS**

8.32 The use of DVDS is a subjective decision for the police. Their decision making has been helped by the Statutory Guidance issued in April 2023. It would be wrong for a review such as this to say whether a disclosure should or should not have been made in any circumstances. The concern for the review, in relation to UK victims of Sam, is that there is no evidence that DVDS was considered proactively by the police. We make a recommendation in relation to this aspect.

8.33 As far as Laura is concerned; there are two issues:

- By the time Laura came to the UK, the police had no information to suggest that she was coming and the information relating to Sam's contact with an unidentified girl from Canada had last been active in 2016; five years previous. Therefore, there was no opportunity in 2021 for the police to consider a proactive disclosure before she arrived in the UK.

- There is no evidence that either Laura or her family sought to make an application under to DVDS before she came; or indeed whether they knew about the opportunity to do so.

8.34 The review does consider, as previously detailed, that had the risk assessment of Sam been made using the newer model then when police attended Sam's home for the report of burglary made by Laura, he would have been flagged as a risk to others and thus the prompt for consideration of DVDS would have been raised at that time.

8.35 The review does not know whether Laura or those supporting her were aware of the DVDS and whether it is available for use by foreign nationals visiting the UK. The review has made a recommendation in relation to clarity around this point.

8.36 **Cross border police issues**

8.37 Sadly, this review echoes some elements found in a previous Essex review (Angel), where cross border arrangements between police forces left a victim being less supported than is desirable. In this case, another victim of this perpetrator had previous experience of Essex Police but had moved to the Metropolitan Police area when she rang to report significant prior abuse. The review accepts that each police force is responsible for its own area, but time spent debating where a person lives and thus who she should speak to, is time wasted in supporting vulnerable victims. The direct impact of this was that the victim was lost to the 'system'. The nature of the allegations made by this victim, are likely, had they been 'gripped', to have resulted in the arrest of Sam at the very least. This may have been disruptive to any plans made for Laura to visit. All acknowledge the courage it takes for victims to come forward. The moment they make that decision is the moment they need support. It seems to this review that when arrangements for contact are passed between police forces, because of where a person lives, then that sense of importance in 'seizing the moment' can be lost. The review believes that clear direction is required to police forces in respect of primacy for support to victims.

8.38 **Consideration of risk in mental health decision making**

8.39 This review and the Independent Mental Health Review feel that more should have been done to identify the true risk posed by Sam and that knowledge of the risk he posed to women, including Laura, was not as formed as it could have been. Recommendations have been made in relation to this issue.

8.40 The review makes a total of 14 recommendations across a range of agencies that we believe will make the future safer for others.

9. Conclusions

9.1 This has been an awful case to review. A young woman, Laura, travelled across the world to meet a young man, Sam, she had only previously conversed with on-line. She was only 19 years old at the time and he was several years older. They had first met on-line when she was only 13 years old, and he was approaching his 17th birthday. This review has no hesitation is saying that she was groomed by him.

9.2 Once in the UK he controlled and coerced her until finally murdering her because she had found the strength to leave him and return to her home country.

9.3 It seems clear that she had no idea of the previous abuse that he had wrought upon a number of previous partners, and his own mother and sister. He was a serial abuser.

9.4 It is also clear that despite being supposedly 'obsessed' with her, he embarked upon a number of abusive relationships during the time of their on-line 'relationship'. It is unlikely she knew about these.

9.5 His behaviour and attitudes towards women were misogynistic to the extreme.

9.6 That the true risk he posed to a number of women was not truly recognised is a key issue for this review. The review acknowledges that the police used a recognised risk assessment framework but believe the work they have done in developing a newer, more inclusive model, will better protect others in the future.

9.7 In addition, we know that services were aware, and concerned about, the relationship when it first began, but did not ever fully identify Laura. That resulted in no action to warn her of his already abusive and obsessive behaviour towards a previous young girlfriend. This review has followed the trail of records to try and understand why she was not identified and accepts the difficulties presented at the time. It was, however, an opportunity that was missed to alert Laura and those who were responsible for her, of the emerging dangers presented by Sam.

9.8 The review has considered this case carefully and has made a number of recommendations that the review believe will make the future safer for others.

10. Recommendations

10.1 Agencies are responsible for completing the actions agreed through the DHR: this includes providing updates to Safer Chelmsford CSP and the SET DA Team. The Safer Chelmsford CSP is responsible for ensuring the action plan is implemented and the SET DA team will be responsible for monitoring and updating the action plan with updates provided to the SET Strategic Development Group (SETSDG). This will include flagging where actions are not completed.

10.2 **ESSEX POLICE**

10.2.1 It is recommended that the procedures for tasking/disseminating intelligence relating to online (Child Sexual Exploitation) is tasked and reviewed.

10.2.2 It is recommended that Essex Police considers how staff investigating incidents involving high-risk domestic abuse perpetrators can be alerted to the offending history, vulnerabilities and risks in the same way as currently happens for domestic abuse incidents.

10.2.3 It is recommended that Essex Police reviews the way in which high-risk domestic abuse perpetrators are identified and communicated to frontline staff, including those dealing with non-domestic abuse related crimes in the home.

10.3 **ESSEX CHILDREN' SOCIAL CARE**

10.3.1 It is recommended that, when young people transition from Children's Social Care to Adult Social Care, Children's Social Care should have a named social worker/team manager from Adult Social Care before closing their involvement. This is likely to avoid neither service holding any case responsibility even though the need for support as an adult has been accepted.

10.3.2 It is recommended that, when a young person presents with intimate relationship violence and mental ill health, their behaviours should be considered with both a mental ill health AND domestic abuse lens to ensure that intervention can address the 'whole child' and the relationship between the behaviours is assessed and understood.

10.4 **ESSEX PARTNERSHIP UNIVERSITY NHS TRUST (EPUT)**

10.4.1 Recommendations to sit within the Independent Mental Health Review being conducted into Sam's care and treatment. Those recommendations will be managed through the NHS England governance process.

10.5 **HOME OFFICE**

10.5.1 It is recommended that an amendment is made to the Government website that clarifies, in simple terms, whether a person visiting a potential partner in the UK has the Domestic Violence Disclosure Scheme available to them.

10.6 **MARAC**

10.6.1 It is recommended that all agencies involved with a case should be present at MARAC when it is heard.

10.6.2 It is recommended that high-risk perpetrators with a pattern of multiple victims should be tracked, and timely MARAC referrals should be made when a new relationship is identified. We acknowledge that form parts of the work being undertaken by Essex Police in respect of perpetrator risk management but feel it is worthy of a recommendation to ensure that DA perpetrators are not underrepresented within that framework.

10.7 **MID AND SOUTH ESSEX NHS FOUNDATION**

10.7.1 It is recommended that the Trust promotes and encourages professional curiosity across all its services through:

- Safeguarding/domestic abuse training
- Policy and process
- Reference on the Safeguarding page of the Trust Intranet site

10.7.2 It is recommended that:

- A Reflect Campaign, targeted at supporting perpetrators, is cascaded to all staff.
- Staff are encouraged to sign up to the SETDAB newsletter for forthcoming training events and attend when available. #Reflect on your behaviour - Southend and Thurrock Domestic Abuse Partnership (setdab.org)
- Work with perpetrators is included in safeguarding/domestic abuse training.

10.8 **NELFT**

10.8.1 It is recommended that when a parent/carer discloses domestic abuse from anyone in the family home, a DASH risk assessment is completed, and the safeguarding team are approached for support.

10.9 **PROBATION SERVICE**

10.9.1 It is recommended that, in light of the recent reunification of probation services, that attendance at MARAC meetings is reviewed and the CSP is assured that systems are in place to ensure that, except for exceptional circumstances, probation will be in attendance when necessary.

10.9.2 It is recommended that professionals' meetings are arranged by probation officers when there is involvement by several agencies working on a case.

10.9.3 It is recommended that professional curiosity is applied to domestic abuse cases when perpetrators are reporting new relationships. It is recommended that, when developing the action plan, probation consider the findings of Phillips et al from Sheffield Hallam University on putting professional curiosity into practice in probation[4].

[4] Lifting the lid on Pandora's box: Putting professional curiosity into practice, Phillips et al, Sheffield Hallam University, Criminology and Criminal Justice, 2022