Safer North Tyneside Community Safety Partnership

Domestic Homicide Review in relation to Jane

Date of homicide August 2022

Executive Summary

Independent Chair and Author: Stuart Douglass

Report completed June 2023

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Section 1 The Review Process

1.1 This summary outlines the process undertaken by the Safer North Tyneside Partnership[1] Domestic Homicide Review (DHR) Panel in reviewing the homicide of Jane, a resident of North Tyneside.

1.2 Jane was unlawfully killed by her former partner George who committed suicide following the homicide.

1.3 In August 2022 Jane had failed to turn up for work. Her colleagues found this out of character and being aware that Jane had diabetes, made several unsuccessful attempts to contact her, including attending her home address. Subsequently police were requested to enter her home. Jane and George were found deceased at the property.

1.4 The police investigation in relation to the homicide concluded in late November 2022 and the DHR commenced.

1.5 This review has been anonymised in accordance with the statutory guidance[2]. The specific date of the homicide has been removed. Only the chair and review panel members are named.

[1] Community Safety Partnerships were established as statutory partnerships under sec 5-7 of the Crime and Disorder Act 1998 and include representatives from the police, local authorities, fire and rescue, health, and probation services (the responsible authorities). The partnerships are responsible for ensuring the commission of Domestic Homicide Reviews.

[2] Statutory guidance for the conduct of Domestic Homicide Reviews, published December 2016, Home Office.

1.6 To protect the identity of the victim, the perpetrator and key contributors to the review, the following pseudonyms have been used:

Pseudonym	Relationship to subject	Ethnicity	Age at time of fatal incident
Jane	Victim	White British	54 years
George	Perpetrator/former partner	White British	65 years
Deborah	Former partner of the perpetrator		
Friend A	Friend of Jane		
Friend B	Friend of Jane		
Friend C	Friend of Jane		
Friend D	Friend of Jane		

1.7 The referral for consideration of a DHR to Safer North Tyneside was made on 09/08/2022 by Northumbria Police.

1.8 The referral was considered in line with Home Office statutory guidance.

1.9 The Community Safety Partnership notified the Home Office of their intention to undertake a Domestic Homicide Review on 16/08/2022.

1.10 6 of 8 agencies scoped confirmed contact with the victim and perpetrator and were asked to secure files.

1.11 The review was submitted to the Safer North Tyneside Board in July 2023 and approved for submission to the Home Office at its Board meeting on

the 7th September 2023. The Home Office indicated approval to publish in April 2024.

Section 2 Contributors to the review

Northumbria Police	Investigation statements
Newcastle Foundation Trust	Individual Management Review
North East and North Cumbria Integrated Care Board	Individual Management Review
Department for Work and Pensions	Information report
North East Ambulance Service	Individual Management Review
North Tyneside Council Adult Social Care	Information report
Northumbria Healthcare NHS Trust	Individual Management Review

Section 3 Members of the review panel

3.1 Members of the Panel were as follows:

Northumbria Police	Ian Callaghan - Detective Inspector Strategic Innovation Partnership Safeguarding
North Tyneside Council	Lindsey Ojomo - Resilience and Community Safety Manager Ellie Anderson - Assistant Director Business and Quality Assurance, Adult Social Care Lesley Pyle - Northumberland & North Tyneside Domestic Abuse & Sexual Violence Lead

Harbour[3]	Lesley Hill - Preventions Worker/ DAPS Team
North East Ambulance Service	Jane Stubbings - Named Lead Professional for Safeguarding Adults, Quality and Safety
Independent Chair/Author	Stuart Douglass
Her Majesty's Prison and Probation Service	Steven Gilbert - Head of Function: North Tyneside and Northumberland PDU
North East and North Cumbria Integrated Care Board	Adrian Dracup - Designated Nurse Safeguarding Adults
Cumbria, Northumberland Tyne, and Wear NHS Foundation Trust	Sheona Duffy - Acting Team Manager Safeguarding and Public Protection / Named Nurse
Northumbria Healthcare NHS Foundation Trust	Yvonne Lawrence - Acting Head of Safeguarding Children & Adults and Acute Liaison Learning Disability Service
The Newcastle upon Tyne Hospitals NHS Foundation Trust	Lesley Sinclair - Named Nurse Adult Safeguarding
Department for Work and Pensions	Jackie Butson - Advanced Customer Support Senior Leader

3.2 The Panel met on 4 occasions. Panel members had no line management responsibility for any staff who may have had contact with Jane and

[3] Harbour is an independent north east charity with over 40 years of providing services to victims of domestic abuse.

George and the chair was satisfied that the panel members and Individual Management Review authors were independent.

3.3 The Review Panel would like to formally express its condolences to the family and friends of Jane for their loss.

3.4 The Review Panel would additionally like to thank those who contributed to the DHR process for their cooperation and participation.

Section 4 Author of the Overview Report

4.1 Stuart Douglass was appointed as chair and author. Stuart is an independent practitioner with over 30 years' experience in safer communities and safeguarding policy and completed Home Office approved DHR training in 2016. Stuart has no connection with the Community Safety Partnership. Stuart had previously worked for North Tyneside Council and Northumbria Police with those employments ending in 1994 and 1997 respectively.

Section 5 Terms of reference for the review

5.1 Terms of Reference were agreed following the initial Panel meeting and are as follows.

5.2 The purpose of the domestic homicide review (DHR) is to:

- Establish the facts that led to the homicide and whether there are any lessons to be learned from the case about the way in which local professionals and organisations work individually and together

- Identify clearly what these 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 victims of domestic violence and abuse, by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to at the earliest opportunity
- Contribute to a better understanding of the nature of domestic abuse
- Highlight good practice

5.3 The review identified the following key lines of enquiry (KLOE):

KLOE 1 - To identify the history of the relationship with regards to domestic abuse and/or coercive behaviour

KLOE 2 - Did any agency have knowledge of domestic abuse and/or coercive control in respect of the relationship between Jane and George

KLOE 3 - To identify service contact with Jane and George and if those services were responsive and accessible

KLOE 4 - Were any agencies aware of the suicidal ideation of George?

KLOE 5 - To consider if there were any barriers to the identification and reporting of coercive control, domestic or other forms of abuse in relation to Jane? (This should include consideration of the impact of the COVID-19 pandemic)

KLOE 6 - Identify any areas whereby local or national improvement could be made to the existing legal, policy or practice framework

5.4 The Domestic Homicide Review followed the methodology outlined in the Home Office statutory guidance. Sources of information included:

- Individual Management Review reports and comprehensive chronology

- Information reports
- Homicide investigation material
- Interview with the victim's family representative
- Interview with the perpetrator's sister
- A combined chronology
- Relevant literature review

5.5 The terms of reference were drafted following the initial Panel meeting. The family representative was consulted and offered the opportunity to comment.

5.6 The review panel considered agency records in detail for the period from August 2020 to August 2022 as it was indicated that the relationship had deteriorated and ended in that period. The review also considered accounts reflecting the period of the relationship between Jane and George (over 18 years) to inform learning.

Section 6 Summary Chronology

6.1 Jane was born in North Tyneside and had one sister and a close extended family.

6.2 Upon leaving school, Jane had worked for a large builder's merchant as an administrator for almost 40 years.

6.3 Jane was close to her family and a circle of close friends with whom she maintained active social contact.

6.4 Jane had met her partner George in around 2004 and he had moved into her home. George was from the north east though did not maintain much contact with his family. He had been previously married and had served in the Royal Air Force. Following his marriage ending in the 1990's he then had a relationship with Deborah and lived with her for 6 months. Deborah

ended the relationship when George had been drinking and struck her child. Jane did not know the reasons for his previous relationships ending. George was qualified as a gas fitter, however in more recent years he had withdrawn from employment. Jane had provided him with a home.

6.5 George socialised infrequently and preferred to stay at home. Jane's family and friends consequently did not know him particularly well despite him having lived with Jane for around 18 years.

6.6 Jane had wished to end the relationship from around 2020 and over a 3 month period in 2022 had asked George to move out, though she had indicated that they could remain friends. Jane had explained that she wished to meet new male friends.

6.7 George had not made any active effort to move out and Jane had become increasingly frustrated by this. In August 2022 Jane had indicated to colleagues and friends that she would give George an ultimatum to leave over the weekend.

6.8 Jane was found deceased some days after this as a consequence of a physical assault with George taking his own life in the house at the same time.

Section 7 Key issues and conclusions

7.1 The terms of reference and specific requests for the agencies providing Individual Management Reviews and chronologies were fully addressed.

7.2 There were no missed opportunities for any agency or family or friends to intervene. There were no indicators that George would kill Jane and himself.

7.3 This report describes and analyses the events which led up to the fatal incident and the panel were able to identify that there were no accounts or recording of any domestic abuse or coercive control history in the 18 years

of the relationship prior to the homicide. In interview (post homicide) neighbours did report occasional raised voices, however, stated that they thought these were "normal" disagreements. Family and friends indicated that they considered that the relationship was not abusive in nature as they felt certain that Jane would have disclosed this in her close and regular private contact with them.

7.4 The panel did consider that there were a very small number of examples of behaviour throughout the 18 year relationship within the context of control or attempts at controlling behaviour. These included George leaving Jane with no money whilst in the middle of a holiday, not contributing to home tasks or improvements that he was qualified to undertake, deciding to withdraw from employment and a reluctance to socialise with Jane's family and friends.

7.5 The panel considered that whilst professionals could consider in hindsight the incident regarding the holiday as controlling behaviour, the examples evidenced by the review were too limited to draw conclusions. Panel discussed these issues at length and on balance were conscious of "hindsight bias", whereby events can be overestimated in terms of their significance once the outcome is known.

7.6 It is important to note that Jane and those who knew her probably may not have considered them as potentially controlling or coercive behaviours. Awareness of these behaviours as constituting abusive behaviours is growing, however, the panel could not identify any evidence to serious alarm or distress which has a substantial effect on day-to-day activities, or to be linked to threats or fear of violence. All accounts from family and friends described Jane as very much in control of what she did in life, and all felt sure that Jane would have disclosed fear or threat. Nonetheless

Panel considered that some of George's behaviours could be interpreted in hindsight to attempt to "control" in a way that allows him to choose his lifestyle within the relationship.

7.7 The review identified no barriers to Jane reporting domestic abuse and the view of family and friends who were close to her is that she would have told them if she had experienced this. (Terms of reference - key lines of enquiry 1/2/5)

7.8 Jane had limited contact with agencies, she was employed and financially independent. Her contacts were limited to routine health issues and no concerns were ever raised or recorded in relation to her interactions with her GP or local hospital services. Jane was seen alone in her appointments and opportunities were available if she had wished to disclose abuse or relationship difficulties. George's contact with agencies was equally limited and no concerns were noted or raised. Services were responsive to both Jane and George in those contacts. (Terms of reference - key lines of enquiry 3)

7.9 No agencies were aware of suicidal ideation in respect of George and there was no evidence that this was apparent to Jane or her family and friends. (Terms of reference - key lines of enquiry 4)

7.10 There was no evidence that the relationship was negatively impacted by the COVID-19 pandemic or that services such as health were not accessible to Jane or George during that period. (Terms of reference - key lines of enquiry 5)

7.11 Jane worked through the COVID-19 pandemic and accounts from family did not highlight this impacting in respect of the relationship though had felt that the limit on travel and social outings may have led Jane to re-evaluate her relationship.

7.12 Accounts given by Jane to her sister and friends indicated that the relationship with George had "faded out" over recent years, though he remained resident in her home.

7.13 Jane had described wanting to the end the relationship for a period of months and she had asked George to leave on several occasions in the 3 month period prior to the homicide. She reportedly had wanted to be sure that George would be ok and have somewhere to live, however George displayed a reluctance to leave, and that clearly was difficult for Jane. She had indicated that she would give a final ultimatum for George to leave at around the time of the homicide.

Section 8 Lessons to be learnt

8.1 Common factors found in domestic abuse and domestic homicides, such as a prior history of domestic abuse are not always visible or present. This review highlights that there was no evidenced history of domestic abuse. Jane had very close relationships with her sister and a longstanding group of close friends. She would readily share her feelings and never highlighted any concerns or fear in relation to George in the 18 years they lived together. The review could only discover limited indications that George's earlier relationships and his family relationship indicated a conflictual temperament. His relationship prior to meeting Jane had ended abruptly due to him striking his partner's child following consumption of alcohol.

8.2 Jane had never indicated that she considered George to be abusive or threatening. This picture changed significantly when Jane asked George to leave her home and he becomes aware that she wishes to engage in new relationships. Jane indicated that despite having asked him to find new accommodation he had not progressed this and she had disclosed to a colleague that she would tell him again over the weekend that the

homicide occurred. This highlights that we must ensure that agencies and the community understand that separation is a critical factor in relation to a significant increase in risk of domestic abuse and that this can be where previously a risk of abuse would be considered negligible.

8.3 Men commit most homicide-suicides, and it generally occurs in the context of separation, divorce, or relational conflict. Victims of the homicide are predominantly female. Depression is a key vulnerability. Risk is greatest in the Intra-familial setting and when the victim and perpetrator are in proximity. Age is a factor and perpetrators of homicide suicide are older in profile than general homicide perpetrators and are less likely to have a history as a domestic abuser.

8.4 This creates some assistance in profiling risk. Agencies in this DHR had no indications of risk but for the future, assurance should be sought that they are aware of these factors. They may for example see presentations of patients or service users that may alert them to potential risks, for example, middle aged males who are recently separated or facing separation, or for example older care givers whose health deteriorates. The Home Office is currently developing a searchable repository of DHR's. This will be of assistance in furthering our understanding in England and Wales in respect of homicide-suicide.

8.5 Although not evidenced in this case the panel considered more widely the barriers of perceived thresholds to friends and family seeking professional advice when they may be unsure if they should have concerns. A recent innovative service development is being developed and will provide a

platform for family or community members to relay concerns about potential victims of abuse.[4]

8.6 There was no single agency learning identified during this review process.

Section 9 Recommendations from the review

Recommendation 1
That the Domestic Abuse Partnership ensure that there is professional and community awareness, that the escalation to abusive behaviours and most serious violence is a significant risk in relationships that are ending, even where there may be no known prior history of abusive behaviour.

Recommendation 2
That the Domestic Abuse Partnership and Safeguarding Adult Board provide assurance that domestic abuse and adult safeguarding training provides frontline staff with skills to understand the profile and risk factors associated with homicide-suicide.

[4] Wearside Women in Need, working with Advocacy After Fatal Domestic Abuse (AAFDA), which will use an investment of £500,000 to tackle domestic abuse through an innovative new approach in the North East. The new initiative will work with communities to increase understanding of abuse and how to safely and effectively help the people you care about. It will focus on equipping family, friends, and the wider community with the skills they need to ensure their voices are heard. The project aims to improve the way services work with families, friends, and the wider community, so that the lifesaving information which they often have, can be shared, and acted on effectively.