Norfolk County Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Into the death of

Kitty in 2014

Report Author

Gaynor Mears OBE, MA, BA (Hons), AASW, Dip SW

Report Completed: 21 August 2015

CONTENTS

Preface

The Norfolk County Community Safety Partnership Domestic Homicide Review Panel would like to express their sincere condolences to the family of the victim whose death has brought about this Review. She was a much loved mother, grandmother, daughter, and sister and will be greatly missed. Her loss has also been keenly felt not only by her friends and colleagues but by those she worked to support.

The independent chair and author would like to thank the relatives, friends and colleagues who have made such valuable contributions to this Review, and to express her appreciation for the time and thoughtful contributions made by members of the Review Panel.

This report of a Domestic Homicide Review has examined agency contact with the victim and perpetrator, who were residents of a town in Norfolk prior to her death in September 2014. The Review will consider agency's contact and involvement with them from 2006 up to the date of the fatal incident.

The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learnt from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death met the criteria for conducting a Domestic Homicide Review under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004, namely the homicide appeared to be by a person to whom the victim was related, or with whom they had, or had been in an intimate relationship. The Home Office defines domestic violence as:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.*
>
> *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*

The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition, and avoids the inclination to view domestic abuse in terms of physical assault only.

DOMESTIC HOMICIDE REVIEW

1. Introduction:

1.1 The circumstance which led to this Review being undertaken are that in September 2014 the perpetrator contacted the Police and informed them that he had killed the victim at their home. The Police attended and found the body of the victim in her bedroom. The perpetrator was arrested and charged with her murder.

1.2 The couple had been married for 21 years, but their relationship had become gradually more distant from approximately 2006. The Review has chosen this year as the time from which the period under review will begin. The couple had formally separated in May 2014, however for financial reasons they carried on living in the same property but led separate lives. The victim had begun building a new life for herself including accessing dating websites; the perpetrator found out about this and asked the victim to stop which she did for a while, he also made requests to restart their relationship which the victim declined.

1.3 On the evening before the fatal incident the victim had spent the evening with friends. When she returned home it is believed that there was an argument between the two. The victim retired to her own room where she found her laptop had been destroyed. She sent texts to friends informing them of this, and one to a family member which indicated that she was anxious about the perpetrator's future actions. She was killed in the early hours of the morning in her room.

Timescale:

1.4 The Norfolk County Community Safety Partnership held a meeting on 10 October 2014 following notification by the Police of the death. The chair and Partnership members agreed that the criteria to hold a Domestic Homicide Review (DHR) were met. The Home Office was informed of the Partnership's decision on 28 October 2014. The Review was concluded on 21 August 2015. It was not possible to complete the Review as required within 6 months due to the timescale of the criminal proceedings which did not conclude until April 2015 after which the Review process recommenced.

Confidentiality:

1.5 The findings of this review are confidential. Information is available only to participating officers/professionals and their line managers until the Review has been approved by the Home Office Quality Assurance Panel for publication.

1.6 To protect the identity of the victim, perpetrator, and their families the following pseudonyms have been suggested by the victim's family and these will be used throughout the Review:

The victim will be known as Kitty; she was 50 years of age at the time of her death. The perpetrator will be known as Brian. He was 51 years of age at the time of the offence.

1.7 Both Kitty and Brian were of White British ethnicity. Neither would have been assessed as a vulnerable adult or an 'adult at risk' the term which has replaced 'vulnerable adult' under Section 14 of the Care Act 2014. As a consequence they did not require and were not eligible for community services to which a person who is aged 18 years or over may be entitled by reason of mental health or other disability, age or illness, and who is or may be unable to take care of him or herself or unable to protect him or herself from harm or exploitation.

Dissemination:

1.8 The following agencies will receive copies of this report:

Chair and Members of the Norfolk Community Safety Partnership
Chief Constable, Norfolk Constabulary
Norfolk Police & Crime Commissioner
Chief Officer, Great Yarmouth & Waveney Clinical Commissioning Group
Chief Officer, Norfolk and Suffolk NHS Foundation Trust
Community Services Manager, Leeway Domestic Violence & Abuse Service
NHS England
Chair of Norfolk Domestic Abuse & Sexual Violence Board
Independent Chair Norfolk Adult Safeguarding Board

Terms of reference of the review:

1.9 Statutory Guidance (Section 2) states the purpose of the Review 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 policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- To seek to establish whether the events leading to the homicide could have been predicted or prevented.

The Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

1.10 Specific Terms of Reference for this Review:

1. The Review will examine the background to the couple's relationship between 2006 when it is understood the relationship began to change, and the date of the victim's death in September 2014. Any agency with information prior to this date are to provide a summary of their contact to assist with context to the events leading up to the victim's death.

2. To establish whether there is evidence of any actions or behaviours that suggest there was abuse or coercive control within the couple's relationship in the past or since they became estranged, either disclosed to services, family, friends, or colleagues.

3. Services who have had involvement with the victim or perpetrator to confirm whether they have a policy and pathway for dealing with domestic abuse, and whether the practitioners who had contact with them had received training in identifying the symptoms of domestic abuse, its effects, and understood behaviours which constituted high risk,

4. To review the couple's use of services and whether there were indications of any other risk factors.

5. If evidence of domestic abuse is found, examine whether the victim or the perpetrator was given or accessed advice and support, and if not why not.

6. The chair/author of the Review will be responsible for consulting family members and for facilitating the contributions of family, friends and colleagues. This will be undertaken through liaison with the Police Family Liaison Officer and the Victim Support Homicide Team.

Methodology:

1.11 A total of 12 agencies were contacted at the start of the review process and asked to check their records for any involvement with the victim or perpetrator. Agencies were asked to secure their files if contact was confirmed. Of the agencies contacted 2 confirmed contact; the couple's GP practice and the local hospital. Both provided detailed chronologies the content of which raised no concerns about domestic abuse, nor were any signs or symptoms which might be an indication of domestic abuse. The contact with the Health sector was either routine or linked to specific health problems. Follow up questions were asked of the couple's GP practice however to ascertain whether they had appropriate domestic abuse policies and training within the practice.

1.12 After contacting the Police family liaison officer the author wrote an introductory letter to two of the victim's close family members enclosing the Home Office DHR leaflet. Telephone contact followed when the Review process and terms of reference were further explained. No relatives were available to contact concerning the perpetrator. Criminal proceedings were delayed and it was arranged to meet family members after the trial concluded.

1.13 As the family lived some distance from Norfolk the author made telephone contact and met them over the final two days of the trial when the jury was deliberating its verdict. Face to face interviews were held with two of the victim's close family members who were in regular contact with Kitty and who knew Brian over the period of their marriage. Three friends and work colleagues were also interviewed one of whom knew both Kitty and Brian. The author wrote to Kitty's biological mother with whom she had been in contact in recent years to inform her of the Review (Kitty was adopted as a baby). However, she felt unable to contribute via interview, but she kindly provided a statement, for which the Review author is most

grateful especially in light of her understandable great distress at the loss of her daughter.

1.14 In the course of the Review the author contacted the Law Society and the ACPO[1] Lead for Domestic Abuse to research the information available for solicitors regarding separation and risk associated with domestic abuse. The Panel also received advice from the Norfolk Community Law Service.

1.15 The perpetrator was sent a letter informing him of the Review and offering him the opportunity to contribute. A response was received saying that he felt unable to take part at that time, but may be able to in some months time if contacted again. As his reply was very near to the completion of the Review and there was very limited agency contact in this case, the chair felt it would be unreasonable and unfair to the family to further delay the Review's completion. A reply was sent to the perpetrator explaining this.

1.16 At the final draft stage of the report the author visited the two close members of Kitty's family who have contributed to this Review and shared the draft report with them. They have corrected some factual inaccuracy, but both were in agreement with the lessons learnt and the recommendations which have been made. They have requested that they receive the web-link to the report once published and this will be forwarded by the chair.

Contributors to the Review:

1.17 The contributors to this Review and the nature of their contributions are:

- James Paget University NHS Hospital Foundation Trust - chronology
- The Couple's GP Surgery, - chronology & information
- Norfolk Police - historical information and relating to the fatal incident

1.18 Review panel members:

- Detective Superintendent Julie Wvendth, Head of Safeguarding & Harm Reduction, Norfolk Constabulary
- Michael Lozano, Patient Safety & Complaints Lead, Norfolk and Suffolk NHS Foundation Trust
- Margaret Hill, Community Services Manager, Leeway Women's Aid, Norfolk
- Alison Thorpe, Head of Service, Temporary Support Housing, Orwell Housing (1st Panel only)
- Walter Lloyd Smith, Safeguarding Adults Lead, East Coast Community Healthcare (1st Panel only)
- Detective Chief Inspector Paul Durham, Senior Investigating Officer, Norfolk Constabulary
- Jon Shalom, Community Safety, Norfolk County Council
- Robert Read, Director of Housing & Neighbourhoods, for the couple's local council area
- Howard Stanley, Senior Nurse Adult Safeguarding, North Norfolk Clinical Commissioning Group

[1] Association of Chief Police Officers

- Ian Sturgess, Domestic Abuse & Sexual Violence Coordinator, Norfolk Police & Crime Commissioner
- Kelly Boyce, Named Lead for Safeguarding Adults, James Paget University Hospital NHS Trust (1st Panel only)
- Gaynor Mears, Independent Chair & Overview Report Writer
- Dawn Jessett, Minutes & Administration for the DHR & Community Safety Partnership

Author of the overview report:

1.19 The author of this DHR Overview Report is independent consultant Gaynor Mears OBE. The author holds a Masters Degree in Professional Child Care Practice (Child Protection) and an Advanced Award in Social Work in addition to a Diploma in Social Work qualification. The author has extensive experience of working in the domestic violence field both in practice and strategically, including roles at county and regional levels. Gaynor Mears has undertaken previous Domestic Homicide Reviews, and research and evaluations into domestic violence services and best practice. She has experience of working in crime reduction, with Community Safety Partnerships, and across a wide variety of agencies and partnerships. Gaynor Mears is independent of, and has no connection with, any agencies in Norfolk in the past or currently.

Parallel Reviews:

1.20 A coroner's inquest was opened and adjourned. There were no other parallel review processes.

2. The Facts:

2.1. Kitty and her estranged husband Brian lived in a town in the county of Norfolk. Kitty was murdered in the home the couple shared there. There were no other residents in the property; Kitty had an adult daughter from a previous marriage who lived elsewhere in the UK. They had been married for 21 years but for the last 5 years of the relationship the intimacy in the marriage had ceased. This coincided with Brian being taken seriously ill in 2008 to the extent that he was seen to change, he was 'not the same old Brian' Kitty told a friend. They had lived in the area for approximately 20 years.

2.2. Their relationship deteriorated further in May 2014 and they decided to separate. As Brian could not afford to live independently they agreed to live separate lives in their home. Kitty began taking steps to make a new life for herself and to broaden her social networks by joining online dating websites. Brian accessed her tablet computer and on finding her use of these websites asked her to stop which she did for a short time. During the summer Brian approached Kitty a number of times about reconciliation, but she did not want this.

2.3. One evening in September 2014 Kitty went to spend the evening with friends who lived within walking distance nearby. The couple she was visiting were friends of both Kitty and Brian. On the way there Kitty had a mobile telephone conversation with a relative, and when she finished the call her friend reports that she called Brian in response to a text he had sent her. The call to Brian took place at the

friend's house and was reported to be an argument. Kitty's friend recalled that Brian appeared not to accept that she was visiting their friends and Kitty gave the phone to her friend's husband to confirm her location.

2.4. On her return home in the early hours of the morning an argument is understood to have taken place. When Kitty went to her bedroom she discovered that Brian had smashed her laptop which she reported to her friend in a text message. She also had text contact with a male friend she had met online who advised her to contact the Police if she was scared of Brian. Kitty sent a text to her daughter telling her that if she did not hear from her later that day to call the Police. This last text did not arrive.

2.5. The following day at 13:37 hours Brian made a 999 call to the Police from outside the Police station and reported that he had killed his wife. Officers attended the property and found Kitty's body in her bedroom. She had suffered multiple stab wounds.

2.6. The post mortem revealed that the cause of Kitty's death was a stab wound to the heart.

3. Chronology:

3.1. Kitty and Brian met in London and were married in 1993. It was Kitty's second marriage. They moved to a town in Norfolk in 1999 where they took up a lease on a shop. Family members report that Kitty worked in the shop from 5am and then worked elsewhere during the day doing two part time jobs. In the evening she would do the books for the shop. Brian managed the shop during the day. Kitty managed the money in the relationship.

3.2. On 16 June 2008 Brian saw his GP as he was feeling very unwell. On the advice of his doctor he went to hospital and was admitted where his condition worsened. On 23 June he was transferred to Intensive Care and put on a ventilator where he remained for some days. A few days after his tracheotomy was removed, and despite the seriousness of the illness from which he was recovering, Brian discharged himself on 4 July and returned home. Explaining this action a relative said that Brian hated hospitals.

3.3. On 8 July 2008 Brian and Kitty had a consultation with their GP. Brian was feeling exhausted. The GP discussed his admission to hospital and the possible ramifications, including the possibility of both of them experiencing post traumatic stress disorder due to the sudden and serious position they had found themselves in due to Brian's time in Intensive Care. Their GP urged them to call if there were any 'mood or functional disturbances'. There were no signs of this at that time, but they were advised what to look for and call rather than put up with things. The GP called the Intensive Care Unit Outreach Team at the hospital and advised that there was a follow up clinic run for patients who had been discharged from the Unit and who have continuing problems (i.e. with relationships, personality problems, etc.) Patients are automatically invited to attend this clinic 2 months after discharge. Kitty told the GP that they had decided to sell their business.

3.4. Brian had three further appointments at his surgery in July 2008 for the dressing of his tracheotomy wound, but there are no further appointments recorded until a routine NHS health check in March 2011. Between the time of this health check and the last entry in Brian's GP records in 2014 there are just four consultations and there is nothing remarkable relating to these appointments.

3.5. Similarly when Kitty saw her GP during the time span under review it was for routine screening, health checks, or relatively minor complaints for example in 2012 she received treatment for carpel tunnel syndrome. There are no appointments which would indicate domestic violence or abuse was a presence in her life; no injuries treated, or signs of low mood or depression.

3.6. Following his illness in 2008 Brian was noted to withdraw into himself. Kitty told a close friend that he "wasn't the same old Brian". Family members and a friend of the couple confirm that although Brian never had much of a social life of his own before his illness, afterwards he became less sociable and preferred to stay at home. Kitty on the other hand had a large circle of friends and she would visit and stay with members of her family around the country and go out with friends locally on her own.

3.7. The change in Brian appears to have affected their relationship and for approximately 5 years there had been no intimacy in their relationship, but in other aspects of their relationship they appeared to have reached some kind of equilibrium which enabled the marriage to continue. Kitty did have a long distance friendship and then relationship with another man, but they did not meet very frequently. Brian had no knowledge of this and the relationship had ended before Kitty's death.

3.8. Kitty and Brian had difficulty in selling their business. The shop was not doing very well in 2010-2011 due to a loss of trade, and they decided to close. However, they still had to pay the lease and their home was guarantee. After the shop closure Kitty continued her three part time jobs, one of which was in a care home for adults with special needs. Her work colleagues report that Kitty was very popular with the residents and she did many fun things with them. Family members report that Brian had short term jobs which were usually found by Kitty as he was not very 'computer literate' and most jobs were online applications which she would complete for him. When not working Brian would mainly stay at home watching television all day.

3.9. There appears to have been a step-change in their relationship in May 2014 when Kitty went away with a group of girlfriends to celebrate her 50th birthday. During the holiday Kitty had a small tattoo, she told her friends she was worried about Brian's reaction as he did not like them. According to friends when she returned home and he found out she had the tattoo he threw his dinner in the bin and sulked for some time afterwards, and then told her their relationship was over.

3.10. Relatives confirm that Kitty consulted a solicitor concerning a divorce and the splitting of the couple's assets, but as there was a mortgage and debts connected with their past business, and their house was security for this debt, she realised that any assets left after the split would be negligible and Kitty had said she did not want to leave Brian with nothing. Kitty told a relative that she planned to do up the house and wait 2 years for a no fault divorce. Brian came to the realisation

that he could not afford to move elsewhere and he suggested that they remain in their home, but live separate lives and Kitty agreed.

3.11. Although Kitty had a full social life with friends and colleagues locally and through her family outside Norfolk, in July 2014 Kitty began accessing a dating website to increase her social circle outside her local area. She appears to have been deliberately discrete and she did not add her photograph to the website. As far as is known her contacts through the website were purely via text message or though the website. Brian discovered that Kitty was using a dating website and asked her to stop which she did, although she continued to text a man she had connected with.

3.12. In August 2014 Brian sent Kitty flowers to her workplace and said he wanted to give their relationship 'another go', but Kitty told him it was over. When Kitty was staying with her relative during that summer she received a text from Brian saying that he wanted to try mediation, but again she did not want to do this as for her the relationship was over. However, Kitty told her daughter in a phone call she did not want to convey this via text message.

3.13. During September 2014 the male friend Kitty had being having a long distance affair with for some years told her he needed a period of time out from their relationship. Kitty then appears to have returned to using the dating website. She told a close friend that she did not think Brian knew she was using a dating website and she added "I don't love him, I haven't loved him for the last 5 years; I'm fed up with living a lie". In text messages to a relative Kitty wrote about life with Brian and how they had grown apart; she wrote "he's just a grumpy old man that I don't know or love".

3.14. At Brian's trial evidence was given that he had accessed Kitty's tablet computer and seen that she was using the dating website once more. He started sending her text messages about wanting to be together, but Kitty did not want this.

3.15. In late September 2014 Kitty went to spend the evening with a close friend and her husband. Brian also knew the couple as they would socialise together when Brian and Kitty were together. As she walked to her friends she spoke on her phone to a relative. When the call ended Kitty noticed a text from Brian and she phoned him when she reached her friend's house. Kitty's friend recalled that the call turned into an argument; Brian was asking her who she was with and saying that he knew she was not with their friends. Kitty passed her phone to her friend's husband to confirm that she was where she said.

3.16. Kitty returned home from her friends at around 3am that night. Brian had bolted the door and Kitty had to knock to be let in; it is believed they had an argument. At his trial Brian alleged that they had talked and that Kitty had said that the man she knew died in hospital, and she wished he had died. However, Brian did not mention Kitty saying these words when he was first interviewed by the Police and they were dismissed by the court. Kitty's relatives and friends are adamant that she would never have said such a thing to Brian. Kitty is then thought to have gone to her bedroom where she discovered that Brian had smashed her computer. He had also put her clothes in bin bags and thrown them out of the window into the garden, although whether Kitty realised this is not clear.

3.17. Kitty is known to have texted her close friend at 3.20am telling her that Brian had smashed her computer. Her last text at 3.36am was to the man she had contact with through the dating website when she told him about the smashed laptop and that she would get up early to retrieve her tablet from Brian. She asked him what she should do and whether she could call the Police. The man thought she should.

3.18. Kitty sent a final text message to her daughter at 4.14am. In the message Kitty wrote "meeting friends in Norwich today. If I haven't phoned you by 9 call the Police. I'm not sure what he might be capable of anymore". This text did not arrive.

3.19. At 1.37pm the next day Brian called the Police from the local Police station and told the call taker that he had killed his wife. Officers attended and found Kitty dead in her bedroom; she had been stabbed. Brian was arrested and charged with her murder.

3.20. At his trial Brian pleaded not guilty to murder; in his defence he cited 'loss of control'. In April 2015 the jury found him guilty of murder. He was sentenced to a minimum term of 16 years.

4. Overview:

Summary of Information Known to Agencies:

4.1. No agencies had any information that could indicate that domestic abuse was taking place within the couple's relationship before the fatal incident.

4.2. The Police had no record of calls or attendance to domestic abuse incidents. Their only involvement was in 2003 when Brian was given a caution for disorderly behaviour linked to an argument with neighbours over parking. In his mid-teens he had a conviction for possession of an offensive weapon, but he had no further offences between these dates.

4.3. GP records are unremarkable, save for the serious illness which resulted in Brian being admitted to intensive care in 2008. However, it is worth comment that although the GP who saw them after his serious illness explained the possible side effects which could arise such as personality changes, and urged them to return if this occurred, this offer was never taken up. Nor did Brian access the follow-up clinic for those who had been in intensive care, although it would appear that he did have some changes to his demeanour if not his personality.

Early Learning:

4.4. Based on the learning from this DHR that the GP practice had not received domestic abuse training other than that contained in safeguarding training, a request was made by the Clinical Commissioning Group Adult Safeguarding representative on the DHR Panel to NHS England East in February 2015 for all GP practices to be sent details of training currently available in the county specifically for GP practices and urging them to attend. This training follows earlier DHR recommendations and voluntary sector specialists Leeway Domestic Violence and Abuse Services were commissioned by the Police and Crime Commissioner's Office

and the Clinical Commissioning Group (CCG) to provide this training within GP practices.

5. Analysis:

5.1. The terms of reference for this Review will be addressed in this analysis after which additional information is to inform the analysis is provided.

1. The Review will examine the background to the couple's relationship between 2006 when it is understood the relationship began to change, and the date of the victim's death in September 2014. Any agency with information prior to this date to provide a summary of their contact to assist with context to the events leading up to the victim's death.

5.2. The background of the couple's relationship has been recorded in the chronology. However, in considering why events may have occurred the period of time from May 2014 when the couple separated and began living separate lives, but living in the same house is perhaps the most critical to the events which occurred. Perhaps the important word here is 'living' separate lives, for Kitty does just that by taking steps to build a new life for herself. Whereas the life Brian lived remained virtually the same with the exception of seeing Kitty finally 'leaving' him emotionally even if she cannot physically leave as they are bound by financial restraint to live in the same house.

2. To establish whether there is evidence of any actions or behaviours that suggest there was abuse or coercive control within the couple's relationship in the past or since they became estranged, either disclosed to services, family, friends, or colleagues.

5.3. There was no evidence of actions or behaviours noted by any of the Health sector that had contact with Kitty or Brian, nor was any abuse of control in the relationship disclosed to them. The last time Brian was seen by his GP was June 2014 and Kitty was seen in May 2014. Both appointments were for medical matters which would not give rise to any speculation that abuse or control was an issue in their relationship, neither did their past appointment history with their GP. At the time of their last appointments they were separated, but from the medical records it would appear that neither mentioned this to their GP, or if they did it was not recorded.

5.4. None of the family or friends saw or knew of any physical violence in Brian and Kitty's relationship either before or after his illness in 2008. Before his illness Brian is described as a chatty person with a sense of humour who did not like arguments; he was described as someone who would back down in the face of confrontation. Brian was seen as always laid back; this may be due to his long term use of cannabis which he would smoke openly. However, even before his illness he did not have friends of his own; his social life was as a couple with Kitty and the friends she made, and so when they separated the change resulted in the loss of the little social life he had, although friends and family explained that Kitty usually socialised with them alone. Brian preferred to be at home, and even when the husband of Kitty's close friend did text him after the separation Brian never responded.

5.5. Kitty had not appeared fearful of Brian when she chose to have a tattoo when away with her friends; she had merely said to friends she was worried about his reaction as she knew he did not like them, but this was not enough to stop her having the tattoo. Of significance is their separation as research indicates that this is the highest risk time for an offender to commit fatal violence, with the first 3 months after separation and up to a year afterwards being particularly high risk.[2] But from her texts and her final phone call on the night she was killed it would appear that Kitty had only just become aware that she faced a threat from Brian, and even then she hesitated to think it serious enough to call the Police. It is not uncommon for victims to down-play or not to recognise an escalation in threatening behaviour, and it appears that although she was anxious enough to text friends in the early hours about what Brian had done that night Kitty underestimated the risk.[3] This was the first anyone knew of any actions or behaviours which could give rise to concern. Could this indicate that there was hidden violence or threats in their relationship before and Kitty had become immune to it until then? Or was Brian finally awake to the fact that Kitty was no longer going to be there for him and he would not accept that change? From the information provided by family and friends, and Brian's statement in court that he did not accept the marriage was over, the latter hypothesis seems the most likely.

5.6. Reviews are asked to avoid hindsight bias, and the Review has been cognisant of this when reaching its conclusions. However, the Review author believes that learning can be obtained with the benefit of hindsight when examining Brian's actions after the separation in May 2014 and for this reason the following observations are included. Changes in circumstances that may have brought about an escalation in risk from Brian's behaviour towards Kitty are:

- Sometime after separation Brian found out Kitty was using a dating website. He asked her to stop.
- He sent her flowers and suggested mediation, but she rejected this.
- Whilst she is visiting family he texted her and asked for reconciliation; she refused.
- In September he accessed her computer and found she is using the dating website once more. He became deeply suspicious that when she went out she was meeting someone indicating growing jealousy.
- He phoned to check where and who she was with when she was spending the evening with the couple who lived nearby; they argued and Kitty proved where she was by handing the phone to her friend's husband disproving his suspicion. Did this humiliate him into a rage because the friends now knew he was acting so jealously?

It must be stressed that the identification of these actions has come about during this Review and no one person had knowledge of all these behaviours to enable them to see Brian's behaviour as concerning, and no specialist domestic abuse agency was involved to identify risk. There is no indication that Kitty was receiving a large number of texts from Brian which would be considered harassment; under Section 1 of the Malicious Communications Act 1998 it is an offence to send an

[2] Monkton Smith J, Williams A, Mullane F (2014) *Domestic Abuse, Homicide & Gender, Strategies for Policy and Practice* Palgrave Macmillan, Basingstoke.
[3] ibid

indecent, offensive or threatening letter, electronic communication or other article to another person.

3. Services who have had involvement with the victim or perpetrator to confirm whether they have a policy and pathway for dealing with domestic abuse, and whether the practitioners who had contact with them had received training in identifying the symptoms of domestic abuse, its effects, and understood behaviours which constituted high risk.

5.7. The couple's GP practice confirms that they do have a domestic abuse policy to guide staff. The practice also confirms that staff have undergone safeguarding children and adults training which contains a domestic abuse element. However, the domestic abuse component of safeguarding training is, by necessity when covering safeguarding, a small component. Although domestic abuse was not identified in this case the practice would benefit from accessing dedicated domestic abuse training.

5.8. During the Review Kitty's colleagues were asked if their place of work had a domestic abuse policy or any posters or information available to staff, for example on staff notice boards. They confirmed that they had never seen a domestic abuse policy and there were no relevant posters or information in staff areas.

4. To review the couple's use of services and whether there were indications of any other risk factors.
and
5. If evidence of domestic abuse is found, examine whether the victim or the perpetrator was given or accessed advice and support, and if not why not.

5.9. There were no indicators of other risk factors and no evidence of domestic abuse was found prior to the fatal incident. Therefore no support services were accessed.

5.10. The only other service accessed was by Kitty who consulted a solicitor regarding her options for separation and divorce. After this, and realising the financial constraints which would affect the couple's ability to live in separate places, the decision was taken that Kitty and Brian would remain in the home, but live separate lives. Solicitors are bound by their professional code of conduct not to disclose their consultations with their clients, therefore the content of their discussion and advice to Kitty is not known. However, having consulted the Law Society the author was told that no information currently exists to guide or advise solicitors regarding highlighting the risks of separation to their client, particularly around remaining in the same home, but living separate lives. The Panel has also been advised by the Norfolk Community Law Service that their checks with the Law Society and the Solicitors Regulation Authority confirm that no specific guidance regarding domestic abuse safety planning is provided to solicitors. However, solicitors are able to purchase the Law Society publication *Family Law Protocol (3rd edition) 2010* which contains a chapter on domestic violence and safety planning. The Panel has not been able to establish the content of this chapter. Nevertheless, information needs to be given direct to clients in this situation; both verbally and via a leaflet they can refer to when considering their options.

6. The chair/author of the Review will be responsible for consulting family members and for facilitating the contributions of family, friends and colleagues. This will be undertaken through liaison with the Police Family Liaison Officer and the Victim Support Homicide Team.

5.11. The chair and author of this Review confirms that this term of reference was completed.

Additional Information to Inform the Analysis:

5.12. Kitty is described by family, friends and colleagues as a gregarious, hard working, resilient woman, who despite many set-backs in her life kept smiling. She had many friends, and colleagues said she was a genuine person, and someone you could confide in, and she had an amazing personality. As an example friends explained how Kitty would get involved in local activities and one friend recalled how one Christmas she dyed her hair green to match her outfit when she dressed up as an elf for a community event. Although friends and colleagues were aware that she was not happy at home she managed to keep a smile on her face; she did not discuss the details of her relationship with Brian, but no one interviewed for the Review thought he was controlling, and some commented that Kitty would never have been controlled.

5.13. In her statement (names changed by the author for the pseudonyms used in this Review) for this Review Kitty's mother wrote:

> *"Kitty was the most loving and devoted daughter I could ever have wished for and I am devastated by her loss. I was fully aware of her marital difficulties with Brian and this aspect formed a part of our last telephone conversation in the hours before her death. However, insofar as I was aware, there was no history of violence by Brian toward Kitty, either actual or implied. To my knowledge, external agencies were neither contacted nor would have even been aware that there was a threat of violence. This is, in my view, a tragic case of a husband who felt that redress for a marital breakup should be a death sentence rather than divorce proceedings. I am unsure how to advise anyone else in Kitty's position on how to approach a marital breakup except to say that separating couples hoping to live peaceful, separate lives under the same roof might be a recipe for disaster."*

6. Conclusions:

6.1 From the information provided to this Review there was no indication that Kitty was a victim of domestic abuse until the fatal incident. For those with knowledge of domestic abuse and the associated indicators of risk it is possible with hindsight to identify actions taken by Brian which suggest risk was growing in the few months before; repeated attempts to make Kitty change her mind about the separation; accessing her computer in her absence to check her internet history; objecting to her use of dating websites, and on the final evening checking on where she was.

6.2 None of the above actions were identified by friends or family as a cause for concern which was understandable as they did not have knowledge about domestic abuse, and those that knew of one or two of the different actions taken by Brian were not in a position to bring them together to form a complete picture. Nor did Kitty herself recognise that she was facing growing risk. It was not until very late on the fateful night that she confided her anxiety that she was not sure what Brian might be capable of when she texted two friends in the early hours. One friend offered an immediate place to stay, and the other advised her to call the Police. Kitty did not appear to think it necessary at that time to take either step. However, it is not unusual for a victim of domestic abuse to minimise her experiences or her concerns, and in this case all evidence suggests that there was no previous abuse to warn Kitty that the argument and Brian's destruction of her computer would escalate into violence.

6.3 With the benefit of hindsight it is easy to fall into the trap of believing that if Kitty or friends had called the Police that night there may have been a chance that Brian's actions might have been prevented. However, without prior knowledge or suspicion that domestic abuse may have been taking place, there was no reason for anyone's concerns to be raised to such a level of alarm to make a call to the Police. Therefore based on what was known at the time of Kitty's murder by agencies, family and friends it was not predictable. Nor was her death preventable by anyone other than by Brian himself.

6.4 From his actions from mid-summer 2014 it would appear that Brian changed his mind about the decision to separate. He sent flowers to Kitty's workplace and made more than one request for mediation and reconciliation. He did not accept that the relationship was indeed over. At his trial when questioned about the relationship being over he said "that's what she thought not what I thought". It may be that, as is the case with many perpetrators of domestic abuse, for Brian the reason why he committed such a terrible crime was his jealousy, possessiveness, and 'if I can't have her no one else will'. Kitty's daughter believes this to be the case.

6.5 The fact that no agency had any knowledge or information which could have prevented the murder and no one, including Kitty, imagined such events could happen does not mean that lessons cannot be learnt however.

Lessons to be Learnt:

6.6 A greater public awareness of domestic abuse and coercive control, and particularly of the risks around separation, could make victims, family, friends and colleagues more aware of potential risks, what to look for, and sources of support. Kitty had a caring family and many supportive friends, but outwardly she was a woman with a cheerful disposition with a persona of a woman in control of her life. Reaching out to women who would not imagine themselves being a victim of domestic abuse, or where there was no risk of abuse until separation, needs a different approach to that often taken where women are seen on posters bruised and cowering.

6.7 A former colleague interviewed for this Review said they were not aware of any workplace domestic abuse policy, nor was information about support agencies, helplines, or posters displayed in staff rooms or areas. This absence of policies or

information materials misses an opportunity to reach and support people in their place of work, a location which for most people will be away from their abuser and therefore a safer and easier place from which to access support services. In addition such materials and policies give a positive message to staff that their organisation is domestic abuse aware and will be supportive of staff facing such experiences.

6.8 What do we learn from Brian's actions? It would appear that he did not accept that the relationship was over and whilst there are organisations available for people in his situation such as counselling through Relate or through a GP practice, it would appear that Brian was not open to services which could support him through difficulties. He did not access the support offered post his admission to intensive care for example. Nor does it appear that he mentioned the separation to his GP or express feelings of low mood or depression. He is described as not very sociable; he preferred to be at home, thus access to public facing information may not be seen by someone with Brian's disposition. Nevertheless campaigns which highlight and challenge abusive and controlling behaviours by perpetrator's to both alert them to reflect on their behaviour as abusive, and which emphasise how socially unacceptable such behaviour is, are worth contemplating.

6.9 It is not unknown for couples who are separating to remain living in the home they have shared during their relationship, be that for economic or other reasons. However, individuals may not be aware of the risks associated with separation, especially were one party may be moving on with their life and the other is regretting the separation. This was the case with Kitty and Brian. Advice needs to be given at an early stage when individuals are seeking legal advice about their options about separation and divorce, but most particularly if they are contemplating remaining in the same home but living apart. Just as there is routine enquiry asking about domestic abuse by maternity services, routine information should be provided about the risks which can following separation to those seeking advice from solicitors.

6.10 It was not possible to find out what advice was given to Kitty due to the solicitor's code of ethics. The Solicitor's Regulatory Authority confirms that even though a client may be deceased a solicitor cannot disclose their client's confidential information without the permission of the executor or personal representative, or a court order. However, this would not include legally privileged information such as the advice given to the client. Therefore a DHR would not be able to ascertain what guidance was given to a victim by their solicitor to assist with the Review. In this case no letters to Kitty from her solicitor were discovered by her family to indicate what advice she may have been given.

Recommendations:

6.11 The following recommendations have been developed from the information provided and the lessons learnt from this Review:

National Level:

Recommendation 1:

6.12 That the Home Office and the Ministry of Justice work with the Law Society and the legal advice charity Rights of Women to develop information for solicitors to give to clients who are separating from their partners which includes the risks associated with separation, especially if there has been a history of domestic abuse, or ambivalence by one party about the separation, and which includes the additional risk associated with remaining in the same property, but intending to live separate lives.

Recommendation 2:

6.13 That the chair of the Community Safety Partnership write to the Solicitor's Regulatory Authority director of Regulatory Policy to request that amendments are made to the code of ethics, or that guidance is issued, which will enable solicitor's to assist with information for Domestic Homicide Reviews where their client's death has met the statutory requirement to undertake such a Review under Section 9 of the Domestic Violence, Crime and Victims Act 2004.

Local Level:

Recommendation 3:

6.14 A previous DHR has made a recommendation concerning public awareness campaigns and the Panel acknowledges the ongoing work currently taking place in the county. However, we would ask that the findings and lessons learnt at paragraph 6.5, 6.6 and 6.7 be borne in mind and that the media and messages in future initiatives are designed to reach as wide a section of the community as possible in as many outlets as possible including where practicable places of work such as staff notice boards.

6.15 The wording of Recommendation 3 is:

That the lessons learnt from this DHR be taken into account within the Norfolk Domestic Abuse Change Programme Communications Plan to include:

a) campaigns aimed at reaching victims, family and friends who would not consider themselves at risk of domestic abuse.

b) campaigns aimed at challenging perpetrator behaviour.

c) distribution and campaign materials and information includes the use of social media, and places of employment for staff notice boards wherever practicable.

Training of GP Practice Staff and Others

6.16 The Review Panel wish to reiterate that while the Review has not discovered any systemic failures by any agencies which could be considered to have contributed to this tragic event, the Panel did acknowledge the need for a continued focus, and

the importance of, training and development of staff supported by domestic abuse policies, best practice, and learning from DHRs.

6.17 The Panel is mindful that previous DHR recommendations have been made concerning dedicated domestic abuse training for GP practice staff and that the Police and Crime Commissioners Office and the Norfolk CCG commissioned Leeway Domestic Violence and Abuse Services to provide this training in 2014-15. The GP practice in this case has confirmed that it has a domestic abuse policy, but staff have only received safeguarding training which contains a small domestic abuse component. The Panel would therefore support the continuation of this GP practice domestic abuse training, and that further promotion takes place to urge all practices still to access the training to do so. As this training is still available and the Norfolk Domestic Abuse Change Programme has a Workforce Capabilities Project to specifically address training and staff culture, no further recommendation will be made in this Review.

APPENDIX A

DHR - ACTION PLAN							
RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Progress Indicator	Date of completion and Outcome
What is the over-arching recommendation?	*National, regional or local level*	*What actions need to occur?*				Green Amber Red	
Recommendation 1: That the Home Office and the Ministry of Justice work with the Law Society and the legal advice charity Rights of Women to develop information for solicitors to give to clients who are separating from their partners which includes the risks associated with separation especially if there has been a history of domestic abuse, or ambivalence by one party about the separation, and which includes the additional risk associated with remaining in the same property, but intending to live separate lives.	National	Develop guidance for solicitors which raises awareness of risks associated with separation, domestic abuse and coercive control and how this should be included in discussions with clients who are consulting them about separation and divorce. Produce information leaflet for solicitors to give to clients about the process of separation and divorce which includes section on domestic abuse and risks to consider around separation and additional risks associated with cohabiting but living separate lives.	Home Office And Ministry of Justice In consultation with the Law Society and Rights of Women	Progress on delivery and completion of recommendation to be report to the Community Safety Partnership Board	March 2016		Outcome: Clients seeking legal advice fully informed of their options and attendant risks which can follow separation and able to make informed decisions concerning their safety. Date completed:

DHR - ACTION PLAN							
RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Progress Indicator	Date of completion and Outcome
What is the over-arching recommendation?	*National, regional or local level*	*What actions need to occur?*				Green Amber Red	
Recommendation 2: That the chair of the Community Safety Partnership write to the Solicitor's Regulatory Authority (SRA)director of Regulatory Policy to request that amendments are made to the code of ethics, or that guidance is issued, which will enable solicitor's to assist with information for Domestic Homicide Reviews where their client's death has met the statutory requirement to undertake such a Review under Section 9 of the Domestic Violence, Crime and Victims Act 2004.	National	Draft content of letter to SRA director provided to CSP Chair including rationale for change requested. CSP Chair emails letter to SRA director.	Community Safety Partnership	Draft content provided to CSP Chair. Letter to SRA sent by Chair. Outcome of request to SRA reported to the Community Safety Partnership Board	24 Aug 2015 21 Oct 2015 March 2016	Green	Outcome: Victim's solicitors able to assist DHRs with information with the potential to increase learning from DHRs. Date completed:

DHR - ACTION PLAN							
RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Progress Indicator	Date of completion and Outcome
What is the over-arching recommendation?		*What actions need to occur?*				Green Amber Red	
Recommendation 3 : That the lessons learnt from this DHR be taken into account within the Norfolk Domestic Abuse Change Programme Communications Plan to include: **a)** campaigns aimed at reaching victims, family and friends who would not consider themselves at risk of domestic abuse, **b)** campaigns aimed at challenging perpetrator behaviour **c)** distribution and campaign materials and information includes the use of social media, and places of employment for staff notice boards wherever practicable.	Local Level	One aspect of the domestic abuse change programme is a commitment to coordinating and targeting the Communications and campaigns around domestic abuse across the county. The project seeks to target messages for a range of audiences including professionals, members of the public and service users. Campaigns will have tailored messages for different groups including universal messages aimed at those who might not recognise the signs of abuse. Market research has been commissioned to understand how the three groups (professionals, the public and service users) access information, what their level of knowledge is and how they would like resources	Norfolk County Community Safety Partnership and Domestic Abuse Change Programme Board	Market research commissioned with scope outlined. Market research undertaken including telephone interviews and online participation. Analysis of responses undertaken and presented to the programme board with recommendations. Resources for professionals and service users developed. Campaigns designed and agreed to raise awareness and influence behaviour. Campaign launched during 'Norfolk Says No to domestic abuse' week in November Evaluation built in: effectiveness of campaigns through a range of activities including monitoring of referrals and a one off market research evaluation.	February 2015 May 2015 July 2015 October 2015 October 2015 November 2015 September 2016	Green Green Green* Green* Green* Green* Green *(on track to meet target)	Outcome: Victims, family members, friends and colleagues, better informed about domestic abuse and able to recognise signs and access support. Healthy relationships promoted to encourage perpetrator behaviour change. Date of completion:

		presented in the future. This includes the use of social media and the internet. There will be the opportunity to explore the scope to model healthy relationships using strengths based approach, and encourage positive behaviour change for perpetrators as part of this message. 'Norfolk men say no' a campaign developed for men to challenge domestic abuse, will be reviewed as part of the programme.					

APPENDIX B

Norfolk Domestic Abuse Change Programme

Led by the Norfolk Community Safety Partnership, the key principle of the Change Programme is to develop cultural change within the county's organisations in respect of domestic abuse in order to facilitate early help and intervention with a focus on encouraging early disclosure. In time the county has aspirations to consider the matter of perpetrator programmes, working with communities to develop resilience, and the joint commissioning of services.

A Change Programme board has been set up and a change manager appointed.

4 work strands underpin the programme:

- Workforce Capabilities Project
- Service Delivery Project
- Communications and Campaigning Project
- Strategy and Service Redesign Project Sponsor

Actions taken to date as of June 2015

- Training has been successfully rolled out for GP practices across the county
- domestic abuse coordinators within Norfolk county council children's services have been appointed – part funded by the PCC. They will be recruiting, training and supporting champions across the sectors so that professionals in universal services have an enhanced knowledge and confidence in asking about domestic abuse.
- A pilot training course for champions is taking place in June/July 2015
- Coordinators will look at developing services according to need through service user input and consultation with each taking a specialist area. One will lead on engaging with diverse groups such as ethnic minorities.
- A market research survey is taking place on perceptions of domestic abuse in order to target messages more appropriately to different cohorts in the county – a multi-agency communications and campaigns strategy will be implemented based on the outcomes of the survey.
- A Norfolk wide domestic abuse strategy which includes an outcomes framework is being developed.
- A commissioning framework for Domestic abuse is also in development, providing guidance for the procurement of services where contact with the public requires safeguarding awareness.

Information provided by the Change Programme Manager - June 2015

APPENDIX C

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Dawn Jassett
Community Safety Assistant
Norfolk County Council
Jubilee House
Falconer's Chase
Wymondham
NR18 0WW

1December 2015

Dear Ms Jassett,

Thank you for submitting the Domestic Homicide Review report for Norfolk to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 21 October 2015.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be an open and honest report which probes and analyses, and which identifies useful lessons. In particular there is excellent representation of the input of family and friends and the report demonstrates a very good understanding of domestic abuse. The Panel particularly commended the Chair for researching the position of solicitors regarding understanding domestic abuse safety-planning when clients are separating.

There were some aspects of the report which the Panel felt could be revised, which you may wish to consider, before you publish the final report:

- The date of conviction in the executive summary is incorrect;
- There are no timescales for implementation of the recommendations;
- The Panel queried whether further anonymisation may be necessary to avoid identifying the town the couple resided in given its small size.

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

INVESTORS IN PEOPLE

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel