DOMESTIC HOMICIDE REVIEW
UNDER SECTION 9 OF
THE DOMESTIC VIOLENCE CRIME AND VICTIMS ACT 2004

IN RESPECT OF THE DEATH OF A WOMAN

'Lorna'

REPORT PRODUCED BY MAUREEN NOBLE
INDEPENDENT AUTHOR

STOCKPORT COMMUNITY SAFETY PARTNERSHIP

Contents

Introduction

Key People

Pseudonym	Relationship	Address
Lorna	Female victim	Address 1
Alan	Husband of Lorna (Perpetrator)	Address 1
Child 1	Child of Lorna and Alan	Address 1

Events Leading to the DHR

1. On a morning in January 2015 Lorna failed to arrive at work and no contact had been made to explain the absence. This was out of character and a colleague of Lorna became concerned. The work colleague made a number of attempts to contact Lorna without success before contacting a mutual friend who went out to Address 1 where Lorna and Alan lived with Child 1.

2. It was noted by the friend that both of the couple's cars were on the driveway. Friend 1 knocked at the door, however despite being there for some time, they did not get a reply.

3. Child 1 had been taken to school as usual by Alan that morning in accordance with their usual routine. Concerns were heightened when Alan failed to collect Child 1 from school that afternoon.

4. Members of the extended family were notified by school and they contacted a different family friend (a serving police officer) referred to as Friend 2 in this report, who went to Address 1 to establish why no-one had collected Child 1.

5. According to a police statement given as part of the investigation, Friend 2 looked around the downstairs hall and saw a shadow upstairs. After receiving no reply and having increased concerns Friend 2 forced entry and entered Address 1.

6. On climbing the stairs Friend 2 found Alan hanging from a rope secured to a beam in the loft. He appeared to have been dead for some time. Friend 2 then went downstairs and into the kitchen and saw Lorna on the kitchen floor. She had severe visible injuries and appeared to have been violently attacked, she appeared lifeless.

7. Friend 2 telephoned police to report what he had found. Two police officers were dispatched and on arrival they continued the search of Address 1 after the property had been entered by an off duty police officer. Police telephoned the ambulance service who arrived at the scene and pronounced both Lorna and Alan dead. The house was sealed as a potential crime scene and a homicide/coronial investigation was commenced.

Background to Lorna and Alan

8. Lorna and Alan were married and had a child, referred to as Child 1 in this report (NB to protect the identity of the Child all references to them will be non-gender specific and Child 1's age will not be referred to).

9. Lorna had a successful career in a public facing role in a large public sector organisation where she had worked for 7 years. When Child 1 was born Alan gave up his career to stay at home and care for them. Lorna continued in her job and it appears that her income supported the family, although Alan had been successful in an entrepreneurial capacity and the couple appeared to be financially comfortable.

10. The couple socialised with a small group of close mutual friends who knew them well. Friends described them as a close family.

11. Lorna and Alan had begun to experience some difficulties in their relationship in the recent past. Lorna had confided in a friend that she was becoming disillusioned with the relationship and that she was considering asking Alan to leave the family home. It is not known whether this had been discussed between them. Alan had also confided in a friend that life was not good. It appears that other mutual friends, work colleagues and possibly family members were unaware of these difficulties as the couple were described in some statements made to the police as being happily married and a 'model' family.

12. It was known by some of the couples' friends that Lorna had had a relationship with Friend 2 in the past. There is no information suggesting that Alan had discussed this with friends or family or whether this was a cause of difficulty in the couple's relationship. However, there is evidence from the police investigation that Alan had intercepted emails from Lorna's computer and may have also had access to text messages of an intimate nature with a work colleague.

Police Investigation

13. A police investigation commenced following the discovery of Lorna and Alan. Alan had left a note indicating that he had killed Lorna and that he immediately regretted his actions. He then hanged himself.

14. As part of the murder investigation police took statements from family and friends, all of which have been viewed by the Chair of the DHR. Extracts from some of these statements are referred to in this report where considered relevant.

Coronial Matters

15. An inquest into the deaths of Lorna and Alan was held on 23rd June 2015. The Coroner recorded the following verdicts; that Lorna had died of multiple injuries inflicted by Alan; that Alan had died of asphyxiation and had taken his own life.

16. The Coroner has issued a Section 28 letter to Greater Manchester Police asking them to conduct an internal enquiry into the circumstances at the scene of the homicide, where an off duty serving police officer entered Address 1 prior to officers being called to the scene. This officer was known to be a friend of Lorna and had had an intimate relationship with her in the past.

17. The DHR Chair and a senior officer from the CSP (in this case the Safer Stockport Partnership) met with the Coroner following the inquest to ensure that all relevant information had been received and to discuss the outcome of the inquest.

Time Period Under Review

18. Following initial responses from agencies the time period under review was agreed as January 2013 to January 2015.

CONDUCT OF THE REVIEW

19. Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set in the guidance.

20. Following the publication of the Home Office Action Plan in March 2012 (particularly Action 74, which gave a commitment to "review the effectiveness of the statutory guidance on Domestic Homicide Review"), guidance on the conduct and completion of DHRs has been updated.

21. The Safer Stockport Partnership (SSP) has commissioned this Domestic Homicide Review. The Review has been completed in accordance with the regulations set out by the Act, referred to above, and with the revised guidance issued by the Home Office to support the implementation of the Act. The Home Office definition of domestic abuse and homicide is employed in this case and this definition is attached to this report at Appendix 1.

22. The Chair of the Panel wishes to express her personal appreciation to the colleagues who have contributed to the completion of this DHR.

Terms of Reference and key lines of enquiry

23. The over-arching purpose of a Domestic Homicide Review (DHR) is to:
Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which 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, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

24. The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

25. It is incumbent upon the review panel to ensure that the daily lived experience of the victim is reflected in the review and that any supporting evidence in relation to knowledge and understanding of the spectrum of domestic abuse, and its impact upon victims is used in the panel's discussions and conclusions.

26. Establish all relevant information / learning from the homicide investigation and the Coroner's Inquest; and
Ensure as far as possible the involvement of the victim and perpetrator's family/friends and employers.
The Panel has noted that the scope of this DHR is limited by the lack of contact by Lorna and Alan with agencies. Information about the relationship between Lorna and Alan has been drawn from statements made by family and friends during the police investigation.
The panel decided not to interview any of the friends of Lorna and Alan who had given witness statements to the police as the statements were very detailed and met the needs of the review.

Specific Terms of Reference and Key Lines of Enquiry

- TOR 1: To establish the circumstances surrounding the homicide of Lorna.

- TOR 2: To establish whether Lorna was known as being at risk of domestic abuse by any statutory agency, non-government organisation (including the third sector) or any other individuals?

- TOR 3: To establish whether any safeguarding concerns by professionals or others were expressed in relation to Lorna, either historically or during the time leading up to the incident

- TOR 4: To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.

- TOR 5: To determine whether it was possible for any agency to have predicted or prevented the harm that came to Lorna.

- TOR 6: To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities and worked together to safeguard Lorna and manage risks posed by Alan.

- TOR 7: To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result.

- TOR 8: To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.

Key Lines of Enquiry

27. Agencies were asked to address the following key lines of enquiry in their short reports and individual management reports.

- Were the services offered by your agency accessible, appropriate and sympathetic to presenting needs?

- Did your agency have knowledge of domestic abuse of the victim? If so how was this acted upon?

- Did your agency undertake any specific assessments or enquiries in relation to domestic abuse of the victim?

- Was your agency aware of any allegations of domestic abuse in relation to the perpetrator and how did your agency respond?

- To your knowledge were the victims' family and friends aware of domestic abuse and were they offered support in responding? Were there any confidentiality issues in relation to family/friends being aware of domestic abuse?

- Was the impact of alcohol, drugs or mental health issues properly assessed or suitably recognised. What action did your agency take in identifying and responding to these issues?

- Were there are any specific diversity issues relating to the victim and/or perpetrator?

- Were adult and child safeguarding issues suitably addressed?

- Were there any issues in relation to capacity/resources in your agency that impacted the ability to provide services to the victim and to work effectively with other agencies?

- Was information sharing between agencies appropriate, timely and effective?

- Were there effective and appropriate arrangements in place for risk assessment and escalation of concerns?

- Do you have a domestic abuse policy that includes guidance, training or supervision for your employees or service users who may disclose domestic abuse? Is your domestic abuse policy up to date and effective?

The DHR Panel

28. Following the notification of the death of Lorna the Safer Stockport Partnership contacted the Home Office and agreed to undertake a Domestic Homicide Review.

29. A DHR Review Panel was established by the CSP and met on three occasions to oversee the process. The Panel received reports from agencies and dealt with any associated matters such as family engagement, media management and liaison with the Coroner's Office.

30. The Community Safety Partnership appointed an independent Chair/Author to oversee and direct the Review and to write the overview report. The Chair/Author has extensive experience in the field of public protection and community safety and significant experience in conducting Domestic Homicide Reviews and Serious Case Reviews. The Chair had no contact with the victim or perpetrator in this case and had no professional or personal contact with any of the agencies involved in the Review prior to the incident occurring.

31. In line with statutory guidance a panel of officers was appointed to conduct the Review. Panel members were selected based on their seniority within relevant agencies and ability to direct resources to the review and to oversee implementation of review findings.

32. A third sector agency with specific knowledge and experience in relation to domestic abuse was invited to serve on the Panel, as set out below.

Designation	**Agency**
Chair of the Panel	An independent consultant with experience of chairing senior multi-agency working groups, public protection proceedings and community safety and conducting Domestic Homicide Reviews. Has no connection with any agency in the commissioning area or with anyone else involved in the case.
Detective Inspector	Greater Manchester Police
Designated Nurse Safeguarding NHS	Stockport Clinical Commissioning Group
Chief Officer	Stockport Without Abuse (Voluntary Sector)
Community Safety Officer	Stockport Metropolitan Borough Council
Deputy Head of Community Safety	Stockport Metropolitan Borough Council
Suicide Prevention Lead	Public Health
In Attendance	
Community Safety Officer – Providing Business Support	Stockport Metropolitan Borough Council

33. The panel consulted with a Social Worker from Stockport MBC Children's Services Department regarding the safeguarding of Child 1. The Chair and Lead Officer also met with the Coroner following the inquest.

34. There were no conflicts of interest recorded during the Review. Authors of Individual Management Reviews and short reports were not directly connected to the parties and did not sit on the Review Panel.

Sources of Information to the Review

35. An initial scoping of agency involvement took place following notification of the death. 22 agencies were contacted to establish whether they had had contact with Lorna, Alan or Child 1. Other than routine contacts with health agencies and education, it was apparent that no member of the family had had contact with any other agency.

36. Following the appointment of the Chair/Author it was agreed that both Lorna and Alan's employers would be contacted to establish whether anything in their employment records indicated that domestic abuse may have been taking place within the relationship.

37. The families of Lorna and Alan were contacted to inform them that the review was taking place and to invite their contributions. Contact was made via a specialist Domestic Homicide case worker at Victim Support and through the police Family Liaison Officer. The family were encouraged to contribute to the review, however they did not accept the offer to become involved, and the panel respected their views.

38. Lorna's mother later asked to receive a copy of the draft report and to be notified and sent a final copy prior to publication. Information was sought from Children's Social Care in relation to the safeguarding arrangements for Child 1. As these arrangements cover the period after the deaths of Child 1's parents these details are not included in this report. However, the Panel was satisfied that Child 1's safeguarding needs were being met.

39. The panel liaised with Children's Social Care in relation to ensuring that Child 1 receives specific support from relevant agencies to assist them in dealing with the traumatic events they have experienced.

40. As Alan appeared to have ended his life by suicide (this was later confirmed by the Coroner's inquest). The panel Co-opted a member of the local Public Health Team with expertise in relation to suicide[1] and suicide prevention to provide guidance on any relevant links between suicide and homicide.

41. This information was of interest to the panel but was not considered to have a bearing on the domestic homicide as Alan had not previously self-harmed or attempted suicide. With hindsight it appears that Alan may have experienced known risk factors for suicide[2] which may have impacted his state of mind. However, the panel could find no evidence to suggest that Alan had murdered Lorna because he intended to take his own life.

[1] https://www.gov.uk/government/publications/suicide-prevention-second-annual-report

42. Authors of management reports were invited to attend a meeting with the panel so that reports could be scrutinised and relevant questions posed to the authors. Amendments and clarifications were made following this meeting.

INFORMATION PROVIDED TO THE REVIEW

Contacts with Agencies

43. The following agencies had contact with Lorna and Alan during the period under review and provided information to the review.

- Greater Manchester Police
- Employer of Lorna
- Employer of Alan
- GP of Lorna and Alan
- Central Manchester Foundation Trust
- North West Ambulance Service
- Stockport NHS Foundation Trust
- School of Child 1

Central Manchester Foundation Trust (CMFT)

44. Lorna had only routine contacts with CMFT. These related to her pregnancy and the birth of Child 1 and physiotherapy relating to a previous road traffic injury. During the 12 months prior to her death Lorna had had no contacts with CMFT. CMFT had no contact with Alan.

Employer of Lorna

45. Lorna's employer provided a short report covering the period of her employment (from 2007 to the date of her death).

46. None of Lorna's line managers were aware of any issues in her home life, or any domestic abuse incidents. Lorna had never disclosed any personal problems to managers.

47. Lorna's Occupational Health file only contained routine health information required of all staff.

48. In conclusion, there was no indication from both current and previous line managers and personal records that any disclosure was made regarding domestic abuse or any personal issues that would need management support.

49. There were no concerns regarding her work or conduct at work that would alert managers to any personal issues that may impact on her ability to undertake her role.

Employer of Alan

50. Alan had recently returned to work following a long period of staying at home as the primary carer for Child 1. Alan's employer had minimal records relating to Alan. His personal file contained only biographical details. The nature of his employment did not involve any form of line management arrangement or supervision.

51. There is no occupational health record that indicates that Alan had raised any issues of a personal nature with his employer.

Child 1 School

52. Child 1 joined the school at Nursery level, moving into the primary school reception class and has remained as a pupil at the same school.

53. The school reported that Lorna and Alan were 'very responsible parents' and always ensured that Child 1 attended school regularly and on time. Child 1 was always smartly presented with all the necessary equipment needed. Homework was always completed and returned on time, Lorna and Alan attended parents meetings to discuss Child 1's progress and supported their learning at home.

54. On the day of the homicide, when neither of Child 1's parents had been to collect them from school, the school telephone Child 1's maternal grandmother to inform her that Child 1 was waiting at school to be collected, this was in line with school policy. Child 1's maternal grandmother came to collect them from the school as arranged. School followed appropriate safeguarding practice in dealing with the matter.

Stockport NHS Foundation Trust

55. Lorna had four appointments with the Foundation Trust during October, November and December 2014. These appointments were all with the orthopaedic outpatient department.

56. Alan had one appointment with the surgical outpatient unit in November 2014 following which he was discharged to the care of his GP.

57. The nature of these appointments has no relevance to this domestic homicide review.

GP Contacts

58. Lorna had no face to face contacts with her GP in the 12 months prior to her death, prior to that she had occasional attendances for routine matters that have no relevance to this review. There were no relevant health issues listed on her health summary. There were no hospital attendance / admissions over this period. There were no indications of domestic abuse and Lorna did not seek information or make any disclosures of domestic abuse to her GP.

59. Alan was seen at the GP surgery during April/May 2014 with a physical health issue which resulted in a hospital referral and physiotherapy. Alan never sought information about domestic abuse, nor did he make any disclosures to his GP in relation to domestic abuse.

60. There were no other contacts in the 12 months prior to the incident. There were no relevant health issues listed on his health summary.

61. In information provided to HM Coroner as part of the inquest Alan's GP noted that historically (13 years ago) Alan had been advised to reduce his alcohol consumption which was very high, it was noted three years later that, whilst this had reduced, it was still at a very high level. No further reference to alcohol consumption was made in the record. Friends reported that Alan 'liked' a drink but that he was a social drinker and was often the person who would offer to drive the car and not drink when friends were out together.

62. Child 1 had no attendances or attendance / admission letters for during the 12 months prior to the incident.

Greater Manchester Police

63. Neither Lorna nor Alan were known to Greater Manchester Police until the homicide took place. Following the homicide Greater Manchester Police began an investigation into the circumstances of the deaths of Lorna and Alan.

64. On the day of the homicide Greater Manchester Police were called to Address 1 at approximately 18.30 hours. Friend 2 (a police officer who was off duty at the time) had attended Address 1 at the request of a mutual friend (Friend 1) and Lorna's extended family.

65. On finishing work at 4.00pm Friend 1 had gone to Address 1 but could get no reply. She noted a light was on and the two family cars were on the drive, Friend 1 put a note through the door. Shortly after this Friend 1 received a call from the Mother of Lorna informing her that Child 1 had not been collected from school as was usual. Friend 1 contacted Friend 2 and asked him to call round at Address 1 because of her and the extended families concerns.

66. After checking the premises and becoming suspicious Friend 2 made a 999 call to the police at 18.24 hours.

67. A Force Wide Incident Notice (FWIN) was created in response to the 999 call which was appropriately headed 'concern for welfare'.

68. Friend 2 relayed to the police that he had searched the grounds of Address 1 and seen a light on in the landing, a curtain closed in the study at the front and all other curtains open. This was unusual, he had spoken to neighbours on either side and they said they had not seen either of the Lorna or Alan that day. There was an uncollected letter in the porch.

69. Friend 2 remained in dialogue with the police operator over the telephone. Friend 2 told the police operator that he was going to "break the small panel window above the door to remove the key from the lock on the inside to gain entry." The police operator informed a Police Inspector at Stockport Division and an officer was despatched to the scene immediately. A PC was the first officer despatched to the scene arriving at 19.01 hrs. Other officers including supervisors and specialist staff attended shortly afterwards when the nature of what had occurred became apparent. At 19.03, two minutes after arriving the PC relayed the following message to the Police control room:

    "Please let CID know, possible murder/suicide."

70. Police attending Address 1 found both deceased inside the house. Lorna had suffered stab injuries and Alan was found hanging from a roof beam in the loft. The Force Duty Officer was made aware of the initial report and asks for the scene to be secured and for an ambulance to be called.

71. At 19.05 a civilian stated that she is contacting ambulance control. An ambulance arrived at the scene at 19.10 hours.

North West Ambulance Service

72. North West Ambulance Service had two contacts with Lorna and Alan.

73. On 14th November 2014 Lorna contacted the 111 service as she had had low back pain for the previous 2 weeks and leg pain for the previous 24 hours. There was no mention of any abuse or assault or cause of the pain. Lorna was having difficulty mobilising and was referred to her GP (within 2 hours) 'Out of Hours service' as this was a Sunday.

74. On the date of the homicide a 999 call was placed to the Emergency Operations Centre (EOC) by the Police. The reason given for the call was that there was a female deceased in the kitchen and a male hanging upstairs. Any other patient details were unknown by the Police at this time. The address was Address 1.

75. A Rapid Response Vehicle (RRV1) was allocated to the incident at 19:07. These vehicles are manned mostly by a Paramedic and can often reach incidents quicker than an ambulance.

76. An ambulance (Ambulance 1 with 2 staff) was dispatched at the same time and arrived at the scene at 19:10. RRV1 arrived on scene at 19:14.

77. An Advanced Paramedic was dispatched to support the crews on scene (QX1) and he arrived at 19:26. A Bronze commander was also dispatched but stood down as the Police confirmed that they were dealing with the scene and therefore no other resources would be required.

78. The patient report form and diagnosis of death forms are missing from the system (they are scanned), therefore no further written details are available.

79. The two crew on the Ambulance and the single crew in the Rapid Response Car attended the patients and confirmed they were deceased.

80. The Advanced Paramedic confirmed that he did not enter the property, but was able to debrief the staff afterwards regarding the incident and to offer them support.

81. No further input was required as the Police were dealing with the suspicious deaths and the crews on scene were stood down; Ambulance 1 became clear at 19:50, and RRV 1 became clear at 19:47.

Perspective of Lorna and Alan's Family

82. Lorna's family were invited to participate in the review. Both of Alan's parents are deceased. Lorna's family were contacted via the Police Family Liaison Officer and by a Homicide Support Worker from Victim Support. The invitation to participate in the review was not acted upon and the panel therefore respected the wishes of the family not to be involved in the review.

83. The panel reviewed information contained in the detailed statements made by friends of Lorna and Alan and decided that they contained sufficient information to determine that there was no disclosure or indication of domestic abuse in the relationship. Some friends were aware of difficulties in the relationship but were adamant that there was no violence, intimidation, coercion or control in the relationship.

LEARNING FROM THE DOMESTIC HOMICIDE REVIEW

Responses to the key lines of enquiry

84. Agencies were asked to address the key lines of enquiry set out at 2.2 above. None of the agencies participating in the review, nor any of the family or friends who provided information/statements to the police investigation had any knowledge or indication of domestic abuse in the relationship.

85. *Services provided to Lorna, Alan and Child 1 were appropriate and fit for purpose. None of the agencies responding to the DHR had any knowledge of domestic abuse between Lorna and Alan at any time during the period under review.*
No action was taken by any agency to address domestic abuse as there was no knowledge or evidence of domestic abuse.
Alan was not identified as a perpetrator of domestic abuse and therefore no actions were identified by agency to respond.
There was no knowledge or evidence of domestic abuse by any agency or family member (although family members did not contribute to the review they did make statements to police which indicate no concerns).
None of the agencies participating in the review identified any issues relating to drugs, alcohol or mental health in relation to Lorna or Alan during the period under review. Alan's GP reported an historic concern regarding Alan's levels of alcohol consumption, however, there is no indication that at any time during the period under review there were concerns regarding this.
There were no specific diversity issues relating to either Lorna or Alan. The victim and perpetrator were both white British.
There were no issues relating to safeguarding children prior to the deaths of Lorna and Alan. Following the deaths of their parents, appropriate action was taken to safeguard.
None of the agencies participating in the review identified any capacity or resource issues that impacted their ability to provide services.
There are no issues of information sharing relating to the case. Lorna and Alan made minimal use of services, where it was necessary for these services to share information this was done so in an appropriate, timely and effective way.
There were no concerns in relation to Lorna, Alan or Child 1 that warranted risk assessment or escalation of concerns.
None of the participating agencies require amendment or new procedures or policies/training as a result of this case. Agencies responding have domestic abuse policies, although it was not possible to determine whether Alan's employer has a specific policy.

86. No other information was highlighted by any agency involved in the review. No further information was highlighted by family/friends contributing to the review.

Analysis

87. The DHR panel could find no evidence of physical abuse in the relationship between Lorna and Alan until the fatal assault leading to this review.

88. The family had little contact with services, other than medical appointments for specific medical conditions that have no relevance to this review. The employers of both Lorna and Alan had no knowledge of domestic abuse or disharmony in the relationship, in particular Lorna's employer observed that she was planning a family holiday and looking forward to it.

89. Police had had no previous contact with the family prior to the homicide and Child 1's school observed the dedication of both parents and their engagement with the school.

90. None of the agencies who provided information to the review, nor any of the information gathered by the police during their investigation, including statements from friends and family (who did not wish to participate in the review) reported any indicators of abuse. Some of the behaviours in the relationship could be construed as coercive and controlling however these related to aspects of the couple's lives which the panel judged should not be included in the published report to protect Child 1.

91. There were indications in the statements made to police by friends that the relationship between Lorna and Alan had become strained over recent years, and both had confided in friends that they were having difficulties however neither ever talked about or reported domestic abuse.

92. Information gathered during the police investigation suggests that Lorna may have had an intimate relationship with a friend of the family in the past and that Alan had suspicions about the relationship. There were also suggestions that Lorna had shared intimate text messages with a colleague and that Alan had been trying to access messages on Lorna's computer in the days before her death[3].

93. These suspicions may have contributed to the relationship difficulties but there is no evidence that either Lorna or Alan were using controlling or coercive behaviour in their relationship.

94. There is no indication in any of the information received by the Review that there were any issues in relation to financial matters within the relationship. Lorna was employed in a senior management position and Alan appeared to be financially secure following the sale of rights to a product he had developed.

[3] https://www.staysafeonline.org/data-privacy-day/privacy-and-domestic-violence/

CONCLUSIONS AND RECOMMENDATIONS

95. The review panel offer their condolences to the family and friends of Lorna and Alan. The panel has concluded that none of the agencies participating in the review, nor the families and friends of Lorna or Alan could have predicted or prevented the homicide or the subsequent suicide of Alan.

96. Other than indications of relationship difficulties discussed with friends, there were no indications that the relationship between Lorna and Alan contained any form of domestic abuse. There are aspects of the relationship between Lorna and Alan that could be construed as coercive and controlling, however it is not possible for the panel to comment on the nature of specific events as the relationship difficulties between Lorna and Alan are deemed to be of a private nature.

97. The panel has concluded that there is no specific learning emerging from this case however the CSP will ensure a continued focus on encouraging anyone who may be experiencing domestic abuse to seek advice and support. Stockport CSP has a robust domestic abuse strategy that includes universal and targeted awareness raising and training for professionals.

98. Agencies participating in the review have demonstrated an acceptable level of awareness in relation to domestic abuse and have domestic abuse polices in place, the Stockport partnership will continue to work with agencies and employers in this regard.

99. The panel noted that paramedics did not complete the necessary certificate following attendance at the scene of death. The DHR Chair has written to NWAS to ensure that this is noted and acted upon in this and in future cases. The panel noted that Alan's employer[4] a national organisation, were difficult to contact in the first instance other than by a general 'enquiries' email address. The Chair of the DHR has written to the organisation suggesting that consideration is given to establishing a point of contact for confidential enquiries related to reviews such as this, to ensure effective communication and the maintenance of confidentiality.

[4] http://www.equalityhumanrights.com/new-guidance-launched-help-employers-support-staff-experiencing-domestic-abuse

Appendix 1

Home Office Definition of Domestic Abuse[5]

Domestic abuse is:
'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;
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'.

This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group. Family members include mother, father, sister, son, daughter, brother and grandparents, whether directly related, in-laws or step family.

[5] https://www.gov.uk/guidance/domestic-violence-and-abuse

Appendix 2

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

Laureen Donnan
Deputy Chief Executive
Stockport Council
Stopford House
Piccadilly
Stockport
SK1 3XE
4 May 2016

Dear Ms Donnan,

Thank you for submitting the Domestic Homicide Review (DHR) report for Stockport (case 5) to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 23 March 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a solid review but felt that it did not sufficiently probe and provide a clear assessment of whether domestic abuse was a factor in the relationship. The Panel suggested that direct contact with the individuals who provided statements to the police may have helped the review panel better understand the dynamics of the relationship. This would have also provided an opportunity to understand whether the individuals would have known where to access support if they had suspected abuse. This could have resulted in enhanced learning and a possible recommendation around agencies reviewing their policies and procedures in relation to domestic abuse to ensure they remained appropriate.

There were other aspects of the report which the Panel felt could be revised, or benefit from further analysis, which you may wish to consider before you publish the final report:

Please reconsider the rationale for the review given on page 6 as the Panel felt this was too narrow. As well as examining the way agencies work together to safeguard victims, a DHR should also view matters through the eyes of the victim to give the review added depth and context;

Reference is made to “Appendix 3” but this document does not appear to exist;

The Panel would welcome clarification on the rationale for redaction;

Please review the conclusion on page 19 to satisfy yourselves that there was no coercive control in the relationship. The Panel felt that some aspects of the perpetrator’s behaviour could be perceived to be controlling;

The report does not reveal whether IMRs were probed;

Clarify if the review has been shared with the family;

The Panel questioned the relevance of including details of the victim's work appraisals;

Please review the description of the incident to ensure consistency. For example, page 3 outlines that two police officers were despatched. However on page 15 the report confirms that a PC was first despatched to the scene;

The Panel felt the review may have benefitted from the input of the individual described as "Friend 2" in the report.

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.

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

Appendix 3

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel
Public Protection Unit
2 Marsham Street
London
SW1P 4DF

7th June 2015

Dear Mr Papaleontiou,

Domestic Homicide Review in the Case of 'Lorna'

Thank you for your feedback in relation to the above case. We have noted your comments and the Chair/Author has now amended the report as requested. For information the amendments are as follows:

The report now provides a rationale as to why Friend 2 was not spoken to. The nature of the friendships between some of the parties was complex and was explained fully in police statements. The panel considered approaching Friend 2 but, on the basis of information received decided there would be no added value in approaching them to participate in the review.

Further text has been added to the report in relation to the rationale for conducting the review; this places stronger emphasis on safeguarding victims and seeing matters through their eyes.

Reference to appendix 3 has been removed.

The paragraph where redaction was requested has been removed.

Text has been added to describe aspects of control and coercion in line with your suggestion.

Clarification is provided that IMR authors attended a panel meeting and were revised based on comments from the panel.

Clarification is now provided that the report has been shared with the family in draft format and will be shared again with Lorna's mother prior to publication.

The paragraphs relating to Lorna's work appraisals has been removed.

The attendance of officers at the incident has been revised to ensure that it is consistent throughout the report.

Yours sincerely,

Laureen Donnan
Deputy Chief Executive