Western Suffolk Community Safety Partnership

Domestic Homicide Review Executive Summary

Two deaths in Suffolk
February 2017

Report Author:
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Report completed: November 2017

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Domestic Homicide Review: Executive Summary

Preface

Before formally introducing this Review, the Western Suffolk Domestic Homicide Review Panel would like to express their deepest sympathy to all of those affected by this awful tragedy.

In particular, the panel notes the contribution of the deceased's family and friends, in particular the surviving children; this Review could not have been completed without their support and challenge. No words that can be written within this report can adequately describe their loss. However, we are motivated to undertake a review and compose a report that properly reflects the circumstances leading to the events of February 2017 and ensures that any lessons learnt are identified so that others can benefit from that learning.

The impact upon those who knew the couple in the years and months prior to the incident is not lost upon us.

The Independent Chair and author of this Review would also like to thank all those staff from statutory and voluntary agencies and organisations who assisted in compiling and reviewing the information culminating in this report; all have been touched by the circumstances.

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Section One
The Process of Review

1.1 This summary outlines the process undertaken by Western Suffolk Community Safety Partnership domestic homicide review panel in reviewing the deaths of a husband and wife who were resident in their area.

1.2 The following pseudonyms have been used in this Review in order to protect the identities of the deceased and their family members:

'Elizabeth' was a white British female. She was 58 years old at the time of her death.

'James' was a white British male aged 65 at the time of his death.

1.3 Elizabeth and James had been married for 37 years and had a number of children together. Elizabeth had left James and moved in with her mother around 4 weeks before the incident that resulted in their deaths. Elizabeth's mother lived in the same town, within a quarter of a mile of the house Elizabeth and James had shared together.

1.4 On a Sunday morning in late February 2017, Elizabeth left her mother's house to visit James at the family home, no-one else was present at the time. She had gone to collect some personal effects and talk about their financial future. James killed Elizabeth in an upstairs bedroom before taking his own life. He had left a suicide note explaining his actions.

1.5 A police investigation into the deaths commenced and a file was prepared for HM Coroner. At the time of writing the inquests into both deaths have not been concluded.

1.6 The Western Suffolk Community Safety Partnership (WSCSP) was notified of the deaths by Suffolk Constabulary the day after the incident. After consulting partners, the Chair of WSCSP took the decision to undertake a Domestic Homicide Review.

1.7 All agencies that potentially had contact with Elizabeth and James prior to the point of the incident were contacted and asked to secure their files. There had been minimal prior agency involvement with the family. There had been no reports of previous domestic abuse.

1.8 Contributors to the Review.

1.9 The following agencies contributed to the Review:
Suffolk County Council
Mid Suffolk District Council
Suffolk Constabulary
Suffolk Clinical Commissioning Group
NHS England, Eastern Region
GP Surgery; Primary Care for James and Elizabeth
Solicitor providing services for James
East of England Ambulance Trust

1.10 The following individuals contributed to the Review.
Family of Elizabeth (three)
Family of James (one)
Children of the couple (undisclosed)
Friends of Elizabeth and James (seven)

1.11 The Review Panel Members.

1.12 The members of the DHR Panel conducting this Review were:

Name of panel member	Role or job title	Organisation
Gary Goose MBE	Independent Chair and Overview Author	
Melanie Yolland	Communities Officer (Safe)	Mid Suffolk District Council
Simon Chase	Safeguarding lead	East of England NHS Ambulance Trust
Jim Gooding	MASH lead	Suffolk Constabulary
Tina Wilson succeeded by Allison Hassey	Safeguarding lead	Suffolk County Council Children's and Young Peoples Services
Clair Harvey	Specialist lead	Suffolk County Council
Christine Hodby	Safeguarding Adults lead	Suffolk CCG
Tash Nicholson	Patient Safety Manager	Norfolk and Suffolk NHS Foundation Trust
Paul Nicholls	LSCB Manager	Suffolk County Council
Jane Ross	Patient Experience and Quality Lead	NHS England
Tabitha Griffin	Safeguarding lead	Suffolk CCG
Rebecca Hughes	Adult Protection Team	Suffolk County Council
Charlotte Belham	Senior Operational Support Manager	National Probation Service
Kim Elvin	Adult Safeguarding Manager	Suffolk County Council
Cllr Robert Everitt	Chair, WSCSP	Western Suffolk CSP

1.13 All panel members were independent of any direct involvement with or supervision of services involved in this case.

1.14 The Independent Chair and Author of the Overview Report

1.15 The Community Safety Partnership took the view that a combined role of Independent Chair and Overview Author was appropriate in this case. They appointed Mr Gary Goose MBE to that joint role. Mr Goose is not employed by, nor otherwise has any conflicting interest with, any of the statutory or voluntary agencies involved in the review.

1.16 A total of six Domestic Homicide Review Panel meetings were held in this case; 3rd April, 15th May, 26th June, 3rd September, 13th November and 4th December 2017.

1.17 Terms of Reference for the Review

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Western Suffolk Community Safety Partnership in response to the deaths of (name) and (name) in February 2017.

1.2 The Review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the Community Safety Partnership has appointed Mr Gary Goose MBE to undertake the role of Independent Chair and Overview Author for the purposes of this review. Mr Goose is not employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2. Purpose of the review

The purpose of the review is to:

2.1 Establish the facts that led to the incident of February 2017 and identify any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

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

2.3 Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident of February 2017; suggesting changes and/or identifying good practice where appropriate.

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

2.5 Review the sufficiency of domestic abuse resource and understanding across the County.

2.6 Contribute to the understanding of the nature of Domestic Abuse with Suffolk (and nationally).

3. The review process

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

3.2 This review will be cognisant of, and consult with, any on-going criminal justice investigation and the process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

4. Scope of the review

The review will:

4.1 Seek to establish whether the events of February 2017 could have been reasonably predicted or prevented.

4.2 Consider the period of five calendar years prior to the events (or other timescales as appropriate, to be confirmed at the first Review Panel), subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

4.3 Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.4 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

4.5 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

4.6 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:
- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5. Family involvement

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

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

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

6. Legal advice and costs

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

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then officers of the Community Safety Partnership will co-ordinate that advice.

7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.

1.19 The Review was conducted cognisant of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised December 2016)

1.18 Timescales

1.19 It was not possible to complete the review within the six-month timescales set out within the statutory guidance for the following two reasons:

i) At the time of the commencement of the Review a live and sensitive police investigation was on-going. Given the paucity of prior engagement by the couple with any service it was felt that the majority of information relevant to this Review would necessarily come from family, friends and work colleagues many of whom could reasonably be expected to be interviewed by the police during their murder investigation and asked to give evidence in any forthcoming Coronial proceedings.

ii) In order to fully understand the couple's relationship prior to the incident and pressures that may resulted in this tragedy, the Chair of this Review felt it necessary to interview a wide range of family and friends. This included visits to family abroad and giving some family and friends time to grieve allowing them the opportunity to give due consideration as to whether they felt able to engage with this process.

1.20 Family engagement

1.21 This DHR sought to engage with the family of the deceased in order to help shape the Review and answer any questions they may have.

1.22 There has been full engagement by the family of both the deceased with the Review. That is to say that members of both Elizabeth and James families have assisted us with understanding the couple's relationship. Most importantly, the majority of the couple's children have engaged with the Review. All of those interviewed were provided with written information explaining the Review, the Home Office leaflet for family and friends and offered specialist support.

1.23 The Review has also identified a previous marriage of James, has spoken with his previous wife and also the child of that marriage.

1.24 A large number of friends of the couple have been interviewed specifically for the purposes of this Review. It is true to say that Elizabeth had a far wider social circle than James and thus care has been taken to ensure balance in the Review's findings.

Section Two
The facts of this case

2.1 Elizabeth and James had been married for 37 years at the time of the incident that resulted in their deaths.

2.2 Prior to meeting Elizabeth, James had been previously married. That marriage lasted around five years and one child was born from it. After his first marriage finished James went through a difficult period. He ended up spending time in prison after being convicted of a robbery and an associated indecent assault (the relevance of these convictions will be commented upon later within this report). When released he moved to the north-east Essex area. For a while it is believed that he lived under an alias in order to try and distance himself from his convictions and his time in prison. It is there that he met Elizabeth.

2.3 At the time Elizabeth was in early 20's and James in his late 20's. They quickly married and subsequently had four children together.

2.4 In the early years of marriage there were several occasions when Elizabeth left James, taking the children with her. When she left she told others that James's behaviour towards her was threatening and intolerable and on at least one occasion said that he had hit her.

2.5 The separations were sudden, relatives of Elizabeth remember her calling and asking them to come and get her in the middle of the night and them arriving, bundling belongings and the children in the car to get away.

2.6 On each occasion, Elizabeth made the decision to go back to James.

2.7 No reports of James's abusive behaviour were ever made by Elizabeth or anyone else to the authorities. All of these incidents occurred whilst the family were living in London.

2.8 The family moved to Suffolk around ten years prior to the incident that is subject to this Review. James was a self-employed carpenter and builder. The move to the property that they owned in Suffolk enabled him to have a work-shop on site and

provided an opportunity for the family to live in a property the size of which was simply unobtainable in London.

2.9 When they moved to Suffolk one of the couple's children had already left home and over time a second did too. This left a family unit of Elizabeth, James and two of the children living in the house. That was the case until the time of the incident that took their lives.

2.10 After they had relocated to Suffolk, Elizabeth's mother also moved to live nearer to them choosing the same town; in fact she lived around 200 yards or so away from the couple.

2.11 The couple seem to have grown apart during their years in Suffolk. James seems to have become so content with his 'lot' that he began to become, away from his work, a somewhat isolated figure. People describe him in a routine of being up early for work but by the end of the day when he returned home he expected his tea ready for him, he would then retire to his 'office' where he regularly smoked cannabis and had a pint of beer. It is accepted that this routine ended with him going to bed on most days by 7:30pm.

2.12 Elizabeth wanted more than this and began to develop a social life in the town in which they lived. She began dancing regularly, undertook some courses (creative writing and counselling being two of them), and, after beginning work at a local shop, gained a small but very close group of friends. There is no suggestion that James objected to her socialising, he simply didn't want to do that himself.

2.13 There is a large body of information to suggest that as time went on Elizabeth became desperate to do something more with her life. She told a number of close friends that there was no longer any intimacy in the marriage; that she was unhappy and many of them could see that she was not the woman she had once been. She told friends about what she described as James's intolerable behaviour towards her. She said he controlled everything she did.

2.14 Elizabeth began to talk openly with her friends about plans to leave James when their youngest child left for University in September 2017. She said she 'had nothing to stay with him for'. James appears to have been oblivious to this.

2.15 During 2015/16 Elizabeth began to go out more and more and her social circle increased. She began a relationship with another man. The relationship was hidden from James and only her very closest friends knew of it. She did not tell her sisters or a small group of her best friends who she had known since childhood and who met up with her every year. Despite not knowing the reason, friends noticed a change to a more 'alive' Elizabeth. As the relationship developed Elizabeth began to spend some nights away from the family home, as far as James knew she was staying with friends.

2.16 In January 2017 however an anonymous note was posted through the door at the family home exposing Elizabeth's relationship.

2.17 James called Elizabeth at work and she went home to be confronted about it. She denied the relationship but left James and immediately moved in with her mother. This was around four weeks before the incident that ended their lives.

2.18 Over the course of that next four weeks Elizabeth became steadfast in her desire not to go back to James. She began to make plans for a future with the man with whom she was in the new relationship. Elizabeth's relatives became aware of the separation but she remained guarded about what she said about the new relationship, largely denying it until such a time as it became impossible to deny it any longer.

2.19 It appears James was initially convinced that she would go back to him, as she always had done in the past. He bought a television and there were a number of conversations between them when he said how he would change and that she could go back home. Elizabeth made some visits back to the house to collect personal items but James would only let her take a carrier bag at a time. Her mother opened a bank account in Elizabeth's name and she got a new mobile phone. She did not like going back to the house and when she did go she never took her purse or her phone for fear of James taking them from her.

2.20 The weekend before the incident James telephoned several of Elizabeth's friends and relatives saying he thought Elizabeth was depressed and that he was sure she would go back to him. All of them told him she wouldn't this time; it was over. James then began to focus on a permanent separation and made an appointment for them both to visit a local solicitor. Elizabeth cancelled that appointment as friends advised her that she needed to see a solicitor separate to James. On the Friday before the incident (which took place on the Sunday) James visited a local solicitor on his own. He was advised that Elizabeth would be entitled to half the assets. He was deeply upset and tearful and it was made clear to him that it was unlikely that he would be able to keep the family home.

2.21 On the Sunday morning one of their children had to be at work, the other child took her. Upon return James asked them to 'make themselves scarce' as Elizabeth was coming over to sort out some things.

2.22 Elizabeth was at home with her mother and her sister and she spoke to James on the phone about going over to collect some bits and talk about money. She asked if her sister could go with her, James refused this in a very aggressive way, shouting down the phone at her and her sister. Elizabeth told her mother and sister that she would only be gone an hour or so but they describe her as being very frightened about going over to the house.

2.23 When Elizabeth arrived at the house James killed Elizabeth by stabbing her multiple times in an upstairs bedroom before hanging himself in the same room. It is clear that pre-planning had gone into that tragic event.

2.24 There had been no prior reports to any agency about domestic abuse existing between Elizabeth and James. The police had received one anonymous referral relating to possible violence from James towards one of the children in 2014, this had been investigated and there was no evidence upon which to base any on-going concerns.

Section Three
Key issues arising from the Review.

3.1 There is a wealth of information obtained by this Review that indicates that the early years of the relationship between Elizabeth and James fall very much within the bounds of a domestically violent and abusive relationship. In later years, certainly for their time in Suffolk, there is information suggesting that whilst no longer violent or intimidating, James maintained a level of control over Elizabeth that would fall within the definition set out above, however, there are those who contend that this was no longer the case.

3.2 Information known to professionals

3.2 This is a case where there was a distinct lack of information known to any agency about the circumstances that prevailed in the family home. There is only the single occasion, in late 2014, where police and children's social care acted in relation to a referral about an injury to one of the children living at the address. There are no other occasions where it would be reasonable to conclude that increased professional curiosity may have led to more disclosure.

3.3 The referral in 2014 was classified as anonymous to protect the identity of the originator of the information. The circumstances are known to this Review and that course of action was entirely appropriate. A professional reported concern when they first became aware of the circumstances; questioning the existence of an injury to the child at school, albeit it had been explained away by the child an accident, in the light of becoming aware that the child may have previously spoken about violence from her father. This demonstrated a good level of professional curiosity.

3.4 The report itself was subject to a process of due consideration and background research through the county's Multi-Agency Safeguarding Hub (MASH). It was agreed that this referral should be subject of a single-agency assessment. That agency would be Children's Social Care.

3.5 Elizabeth, James and the child were all subsequently interviewed separately about the issue and provided a consistent account as to how the injury occurred. It was explained as an accident. The case was closed with comments that there was no additional information to suggest on-going or historical abuse and that her school reports are positive.

3.6 During the course of this Review Children's Social Care staff also looked at other information about the family written in 2000 in another local authority area. Scrutiny of that file indicated nothing other than positive parenting with both parents involved fully with caring for their children and addressing any issues that arose. The nature of that source information is not relevant for the purposes of this Review.

3.7 In all the circumstances, the closure of the case following assessment, seems entirely appropriate. The information gathered during the assessment did not meet the threshold set out in Section 47 Children's Act 1989 requiring further action. A letter was sent to the family (addressed to Elizabeth and James) letting them know the outcome and offering additional support at any time.

3.8 This should not be seen as a missed opportunity to uncover domestic abuse in this case. It was an opportunity, but that opportunity can only progress if those subject to abuse provide the information when it arises. There is no suggestion that Elizabeth was being subjected to physical abuse or violence by the time this issue arose and thus she probably didn't think her unhappiness warranted disclosure when the investigation was based upon a suggestion of physical violence to one of her children. An investigation, appropriate to the circumstances that prevailed at the time was undertaken and there were no other missing pieces of the jigsaw that the authorities were aware of or could reasonably have been expected to have been aware of at the time.

3.9 The full disclosure of medical records for both Elizabeth and James do not show any opportunities where it is reasonable to consider that professional curiosity could or should have been greater.

3.10 This Review is grateful for the engagement and candour provided by the solicitor whom James visited two days before the incident. The Review has explored whether the solicitor felt there were any safeguarding concerns in the way in which he presented and what support is available for solicitors who deal regularly with hugely emotive issues. The solicitor in this case noted the availability of peer support together with the resource of the Law Society's Professional Ethics Division telephone line. Had the circumstances been slightly different, and had the solicitor been concerned that James might have done something to harm himself and/or Elizabeth then advice was readily available as to the circumstances in which the duty of confidentiality could be over-ridden. The information provided by the solicitor demonstrates good indicators of reflective practice and also reinforces a view that had James presented in a way which caused concern then the solicitor would have sought professional advice and assured themselves of the risk that James posed there and then

3.11 Other information known about the couple

3.12 There is significant contradiction in the in the information gathered by this Review as to the tensions that existed in the marriage and whether James exerted any level of control over Elizabeth in recent years. There are, though, some areas of common ground which this Review considers significant.

3.13 Firstly, the couple separated on several occasions when the children were very young. This was as a result of what Elizabeth took as intolerable behaviour by James. It may well have included physical violence but even if it didn't it was intimidating enough to make Elizabeth scared of him. It is reasonable, from the large body of information known to this Review, to conclude that James must have been an intimidating man in his younger days. Not only is there the evidence of the separations and what others witnessed of that time, but also the relevance of James's criminal convictions.

3.14 A person's previous criminal history is not always relevant for the purposes of a DHR, however in this case some elements of it are. James was convicted in the late 1970's of the offence of robbery together with an indecent assault upon the victim

of that robbery. For the purposes of clarity, the offence of robbery is committed when:

"A person steals, and immediately before or at the time of doing so, and in order to do so, uses force on any person or puts or seeks to put any person in fear of being then and there subjected to force"

3.15 The offence of robbery is thus inherently violent, it is about the use of violence or the threats of immediate violence. It is about being personally intimidating.

3.16 This Review is unclear about whether Elizabeth knew of the specifics of his convictions or indeed whether she knew of his convictions at all. If she did, or if she became aware of them, then that must have only heightened the level of intimidation she must have felt. If she did not, then the convictions themselves remain an indication of James's character at the time.

3.17 When Elizabeth went back to James on each occasion she gave him more power and control over the marriage and the family. She told her family and friends that she gave in to his behaviour because she felt he could provide for her and the children. It seems reasonable to conclude that the effect of James's early behaviour towards Elizabeth stayed with her for the rest of their marriage.

3.18 Whilst the physical violence and intimidation reduced over the years, and there is no evidence of any in recent years, James had achieved such a level of control over her in those early years that he probably felt there were no longer any problems between them; he probably did not even recognise the long-lasting effects of those years. He was the strong man, the provider for the family, she was his wife and she would do what he wanted. Even when she wanted to do other things it was in his gift to accede to them or not.

3.19 Elizabeth told others that she was deeply unhappy over the years and there is no doubt that this brought her to tears at times. The information from those who have known Elizabeth all or almost all of her life is compelling in this respect.

3.20 The move to Suffolk came at a time that the family were growing up. James was content with what he had achieved. I have no doubt that in his view he had a good family, a good home and a good life. Elizabeth was there for him; the excesses of the past were gone and no longer a source of tension in his eyes. As that level of contentment grew he became more and more socially withdrawn. Elizabeth on the other hand wanted more out of life still, the children were growing and leaving. She faced the prospect of life looming with a man who in her mind showed her little love, no intimacy and had in many ways settled for a life well below the excitement that she still needed. As she began to grow her social life, remote from the life she had at home with James, it was almost inevitable that she would look for the elements she felt were missing, elsewhere.

3.21 That Elizabeth left James following the discovery of the relationship made her vulnerable to the tragedy that followed. All of the evidence and research conducted into deaths following domestic violence and abuse indicates that victims are at their most vulnerable at the time they make their decision to leave.

3.22 The evidence of what then followed is clear and identified in the police investigation. To begin he probably thought she would go back to him. When he was told by others that was not going to happen he set in train a sequence of events that ended up with him taking both their lives. His life, as he knew it and expected it to be, had been taken away from him in his view by Elizabeth. He was not prepared to accept that. The prospect of probably having to lose his home, start his business again and probably be living alone in older age, was too much to bare. He had lost control.

3.23 His final act, in taking the life of Elizabeth and then his own, gave him complete control back.

3.24 Those who knew how Elizabeth was feeling ask themselves if they could or should have done more. Some of her friends told her to get the police to go with her when she collected her things because she was so scared; she did not take that advice. Some did not know who to speak to or where to go for advice to help Elizabeth and have said there should be a national advice line 'like Childline'. Others say they told her to tell James about the affair she was having and her plans to leave before he found out in some other way. Elizabeth was vulnerable, the single most vulnerable point was when she was alone with James. She recognised that was the case but as is sadly true of many cases she underestimated that level of vulnerability.

3.25 The learning arising from this Review must be about whether services and advice for victims, witness or those with concerns about people suffering domestic abuse in Suffolk are sufficient as opposed to issues of individual learning for organisations.

3.26 A significant amount of work has been undertaken in Suffolk to understand the perspective of victims and witnesses, co-ordinate the lessons learned from Reviews such as this, and developing a truly co-ordinated partnership approach to tackling domestic abuse. In 2014/15 the Suffolk Police and Crime Commissioner funded a research paper; 'Understanding Domestic Abuse in Suffolk, A study of the experiences of survivors'; A partnership strategy for Domestic Violence and Abuse has been put in place; and a mechanism for ensuring that the learning from all safeguarding reviews is now underway. This Review makes subsequently makes three recommendations to further support this work.

Section 4
Conclusions and recommendations

4.1 This is a truly tragic case. Four children have lost their mother and father. Others have lost loved family members and friends.

4.2 It is clear that there was a significant amount of information known within a small group of family and friends about the unhappiness that existed within this marriage. A marriage that had lasted 37 years. That information was not known to any of the statutory or voluntary agencies that support victims or otherwise tackle domestic abuse within the county. Many of those who knew about the difficulties said they did not know where to go for advice about how to help Elizabeth.

4.3 There had been no historic reports to any agency of domestic abuse between James and Elizabeth. There is though, evidence of violence and threats from James to

Elizabeth in the early years of marriage causing her to leave him on several occasions. The effect of those early issues never left the couple and, although the violence ceased, the control James exerted on Elizabeth after she had gone back to him on each occasion remained.

4.4 This was a marriage that was disintegrating in recent years with a husband and wife who had come to want very different things in life. Elizabeth gained a new circle of friends and with that the confidence to begin a new relationship. She had planned to leave James later in the year but the relationship was exposed by an anonymous letter being posted through the door of the family home. The manner of that exposure contributed to, but cannot be said to have singularly caused, this tragic event.

4.5 This Review confirms that the single highest risk factor for extreme domestic violence is at the point of separation. The fact that the couple had been separated for four weeks or so did not diminish that risk as so much continued to develop in those early weeks of separation. In this case, an acceptance that Elizabeth was not going to go back to him coupled with a realisation that he might well lose what he had considered was likely to be his home for the rest of his life, all came three weeks after Elizabeth had left. That knowledge resulted in this tragic ending.

Example of good practice and our consolidated recommendations:

4.6 **Example of good practice (professional curiosity)**

The referral to the police in 2014 of the potential of violence towards one of the children by James showed a good level of professional curiosity and is thus a testament to the level of safeguarding awareness in Suffolk police.

4.7 **Recommendation 1:**

A programme of robust communications should be developed aimed at increasing awareness, knowledge and understanding of domestic abuse, coercive control and associated risk among potential victims, family, friends, colleagues, employers, professionals and the community. The campaign should include appropriate sources of support for children, and profile abusive behaviours used by perpetrators with the aim of challenging the behaviour and making it socially unacceptable.

4.8 **Recommendation 2:**

The promotion of a safe and, if necessary, anonymous reporting mechanism should be identified for advice and third-party reporting of concerns by those who have knowledge of domestic abuse being experienced or perpetrated by someone they know.

4.9 **Recommendation 3:**

That all primary and secondary schools across Suffolk help children to understand healthy and respectful relationships.