Western Suffolk Community Safety Partnership

Domestic Homicide Review Executive Summary

The deaths of Oscar and Denise
November 2014

Report Author:
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Report completed: 30th January 2016

Before formally introducing this Review, the Western Suffolk Domestic Homicide Review Panel would like to express their deepest sympathy to the families of all those involved in this tragedy. This Review could not have been completed without their challenge and support.

In particular, we would like to make special mention of the fact that our thoughts are with the surviving children of the deceased. 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 13th November 2014 and one that ensures that any lessons learnt are identified so that others can benefit from that learning.

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

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WESTERN SUFFOLK DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Section 1: The Review process

1.1 Introduction and agencies participating in the Review.

a) This summary outlines the process undertaken by the Western Suffolk Community Safety Domestic Homicide Review Panel in reviewing the deaths of two of its residents. Those deaths having occurred on 13th November 2014.

b) At just after mid-day on Thursday 13th November 2014 police were called by a member of the public who reported a man had been found injured outside a Multi-storey car park in Suffolk. Police and paramedics attended the scene but the man was found to be deceased.

c) As a result of the enquiries made a short while later, the body of the deceased's estranged wife was found in the house she rented a short drive away. She had suffered a violent death resulting from significant head injuries.

d) The couple were married but separated and had children who were orphaned by these events.

e) As a result of these findings Suffolk Constabulary launched a murder investigation. They were subsequently satisfied that no other person was involved in the deaths and concluded that the evidence available suggested that the deceased male had killed his wife and then killed himself. A full report was prepared for HM Coroner.

f) On 29th July 2015 HM Coroner held an Inquest into both deaths. Members of the deceased male's family were present and the family of his wife were present by way of a telephone link to their home in Zambia. At the conclusion of the inquest HM Coroner recorded findings of Unlawful Killing in respect of the death of the deceased female and Suicide in respect of the death of the male.

g) The Western Suffolk Community Safety Partnership had been notified of both deaths by Suffolk Constabulary on 17th November 2014. There followed meetings of a Domestic Homicide Review Advisory Panel which took place on 25th November and 9th December 2014.

h) As a result of those meetings the Chair of the Community Safety Partnership made the decision to undertake a Domestic Homicide Review. The Home Office was notified of the decision on 12th December 2014 and the Review process commenced.

i) An Independent Chair was appointed on 17th February 2015; the review commenced immediately thereafter. Three Domestic Homicide Review Panel meetings were held in this case: 30th March, 2nd July and 5th November 2015.

j) The Chair of the Review presented its draft findings to the Community Safety Partnership at its meeting on 18th November 2015. The Review was completed in January 2016.

k) It was not possible to complete the Review within the six month timescales set out within the statutory guidance due to appropriate care and sensitivity taken by all involved as to the importance of contact with the surviving children in this case and the proximity of this review to HM Coroner's inquest.

l) The following agencies contributed to the Review:

- Norfolk and Suffolk NHS Foundation Trust (Mental Health Services): By way of Individual Management Review (IMR) and Panel membership.
- GP Practice (for both deceased and their children): By way of chronology and written peer review. Practice manager as Panel member.
- Ipswich Hospital NHS Trust: Chronology.
- Suffolk Constabulary: By way of IMR, provision of additional information on the murder investigation, family liaison officer engagement, Panel membership.
- HM Coroner: By way of engagement with the review and provision of reports prepared by the police in readiness for the Inquest.
- Suffolk County Council, Specialist Domestic Abuse Advisor: By way of general information, provision of policy and practice. Panel membership.
- Suffolk County Council Children's Services: By way of IMR, additional information. Panel membership.
- Suffolk County Council Education Services: By way of written information and introduction to schools. Panel membership.
- Children and Family Court Advisory Support Service (CAFCASS): By way of written report
- Schools (anonymised to protect children's identity): By way of personal interview and correspondence. Panel membership.
- East of England Ambulance Service: By way of IMR and Panel membership.
- National Probation Service: By way of Panel membership
- Suffolk Police and Crime Commissioner: By way of personal interview by the Chair of the Review.

m) The following individuals contributed to the Review.

- Family of Oscar (including the surviving children): By way of personal interview with the Chair of the Review.
- Nanny appointed to the children of the deceased: By way of personal interview with the Chair of the Review.
- Family of Denise: By way of correspondence by email.
- Counsellor to Oscar and Denise: By way of personal interview with the Chair of the Review.
- Solicitor to Oscar: By way of background information

n) The following agencies declined to assist the Review:

- Solicitor who had represented Denise in the Family Court process

o) In order to protect the identity of the victims and their family members, the following pseudonyms have been used hereafter within this report:

    a. Male victim: Oscar. He was 37 years old at the time of his death

b. Female victim: Denise. She was 39 years old at the time of her death.

p) Oscar was a White British male. Denise was an African (Zambian) female. They were married but separated. Oscar had custody of the couple's children.

q) To protect the identity of the children in this case, any details which may lead to their identification are being withheld from the report. In addition, details of the information they provided to assist the Review is included **only** where it is considered absolutely necessary to assist the readers understanding.

1.2 Purpose and Terms of Reference for the Review

a) Statutory Guidance 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 upon, and what is expected to change as a result.

- Apply those lessons to service responses including changes to policies and procedures as appropriate.

- 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 up to the homicide could have been predicted or prevented.

b) 1.2.2 Specific Terms of Reference for this Review

"Terms of Reference for the Domestic Homicide Review into the deaths of Denise and Oscar

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Western Suffolk Community Safety Partnership (WSCSP) in response to the deaths of Denise and Oscar on 13th November 2014.

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 WSCSP has appointed Mr Gary Goose to undertake the role of Independent Chair and Overview Author for the purposes of this Review. Mr Goose is not employed by, or otherwise has any conflicting interest 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 on 13th November 2014 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family. **The welfare of the surviving children in this case is of paramount importance and this review will be cognisant of that at all stages of the inquiry.**

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 on 13th November 2014; 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.

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 2013).

3.2 It will be cognisant of the process agreed by Suffolk Community Safety Partnerships and contained within the reference document. "Conducting a Domestic Homicide Review (DHR): Suffolk Protocol and Guidance, July 2012 (revised 2014)".

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

3.4 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.

3.5 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 13th November 2014 could have been reasonably predicted or prevented.

4.2 Consider the period of three 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 and friends to provide a robust analysis of the events, cognisant of point 2.1 above.

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, the way they worked together 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."

1.3 Agency contact and information learnt from the Review

a) Oscar is a white British man from a well-established family with roots in rural Suffolk. Denise is a Zambian national who came to the UK to further her education. The couple met whilst working in London and married in Zambia a matter of months later in 1998.

b) Together, the couple had children. At the time of the couple's deaths the children were all of school age.

c) This Review has learnt that the marriage was in difficulties from an early stage. In 2000, just over two years after the wedding, Oscar had a series of private

counselling sessions where he disclosed that he knew he needed to end the marriage because of what he described as Denise's behaviour, including her heavy drinking. She had, at the time of those counselling sessions, left for Zambia with their child and it was unclear as to whether she would return.

d) What is apparent is that Denise was a troubled woman and became unfulfilled by her marriage. She disclosed to the Counsellor whom she saw for only a few visits; to the CAFCASS officer and also her GP what were very significant issues of abuse which took place during her childhood. This, together with what she described as Oscar's overwhelming nature, made marriage, and then motherhood, very difficult to cope with. She quickly developed an acute alcohol problem and there is also evidence latterly of some illegal drug use. Whilst at one point she began to discuss and perhaps began to address them within the confines of a professional counselling relationship, she ultimately failed to progress those discussions. She began to spend more and more time away from the family culminating in an unannounced lengthy stay in Brazil from September 2013 through to the May of 2014. When she left, Oscar began Family Court proceedings; in his view this was to protect his children from her behaviour. He subsequently commenced divorce proceedings.

e) There is some evidence of violent behaviour by Denise towards Oscar, he received an injury to his ear after what is said to have been a knife attack on him in before his mother's funeral in 2000. It is clear that her behaviour had the capacity to be volatile including a level of physical chastisement of the children unsuited to the modern age and strong evidence that she would use the car and drive the children around when severely intoxicated.

f) Both the deceased, together with their children, were well known locally. They lived in a small rural Suffolk town where Oscar had taken over the running of the well-established family business.

g) The paternal family were a close knit, supportive family unit. Oscar had three siblings all of whom lived nearby, his father and step-mother were also close by.

h) None of the maternal family lived in the UK. Denise was a Zambian national and her mother and sisters still lived there. Her mother visited the UK on occasions and Denise also visited Zambia.

i) Whilst they were well known locally, Oscar and Denise had minimal contact with statutory agencies; other than in very recent years Oscar's increasingly frequent use of his GP and latterly mental health services. Denise was not known to any statutory body for any other than what could be described as routine issues. The children too were not thought of a cause for concern by any agency that had contact with them prior to their parent's deaths. There were, however, some opportunities where information could have been linked together which may have resulted in additional support to the family.

j) There is an abundance of information directly available about Oscar; information about Denise is relatively difficult to find. However, her interaction with figures of confidence such as Counsellors, GPs and CAFCASS together with the information held within the police investigation has provided sufficient detail to show what had become a completely broken and damaging relationship between the two. The

effect upon their children of firstly the relationship and its breakdown, and then the tragic events that followed cannot be overstated.

k) All of those who knew Oscar describe him as a caring father, completely devoted to his children but also completely devoted to and possibly obsessed by his wife. Equally, however, he is described as someone who really struggled with life. He was someone who would find it very difficult to sometimes know which way to turn. would be absolutely convinced about something one day, and the next day would apologetically change his mind. In discussions between that Counsellor and the Chair of this Review the words 'lost and frantic' were ones that best described him when seen by her.

l) His children describe him as totally protective of his wife, even at the height of what they witnessed as her negative behaviour towards him. He found it difficult to stand up to her when she, in their words, regularly beat them. It was only when she was away in Brazil for the substantive period from September 2013 through to May of 2014 that he seems to have realised that their relationship was truly over.

m) During that critical period from September 2013 to May 2014, Oscar, initially full of stress, anxiety and loss, began to slowly recover to a period of relative calm. He employed a Nanny, it appears he began a fledgling relationship and began to adjust to life without Denise around. Her return to the UK and the ensuing Family Court and divorce proceedings resulted in levels of stress and anxiety developing into clear mental ill-health, a brief and voluntary admission into a psychiatric unit and very real plans of suicide. His family describe those times vividly; he lost the will to get out of bed, he became at times unkempt, he was so suicidal that the family took turns to keep him under constant supervision.

n) Whilst all those spoken to accept he was truly suicidal there was very little information to suggest he posed a threat to Denise. However, on two occasions Oscar said he had thought about killing her. It was said to a new partner as part of what she considered a somewhat light-hearted conversation about the effect that partners can have on one. Secondly, he told his sister at his time of his deepest despair that he could only see one way out, that was to kill Denise and himself. He immediately retracted it and it was thought of as a figure of speech. Neither of these people should reproach themselves. They were aware of the context in which it was said and it is now, only with the benefit of the full horror of what is known that it takes on a different and sinister context.

o) The children describe the levels of physical chastisement they received from their mother as 'beatings'. She denied this, accepting that she used to smack and hit them, but saying they were being disciplined which was acceptable in her culture. The children, however, also say that they were told by both their parents they must never tell anyone about the beatings, otherwise they would end up being taken to an orphanage or their parent's would be taken away from them. To the Review, this indicates a level of knowledge that both parents knew the level of chastisement was wrong.

p) It is health professionals, in particular the GPs, who had more contact than any other body with the deceased prior to their deaths. The majority of information concerns

contact between the GPs, and latterly a local NHS Foundation Trust who provide mental health services, and Oscar.

q) Contact between the police and the family is limited to four potentially relevant interactions. A call from a member of the public in 2004, who reported a car being driven erratically with the female driver probably drunk. The family were not spoken to in relation to this report. In 2008, Oscar reported Denise as 'missing'. The police immediately followed this up and made contact with her in Brazil where she said she was on holiday. In 2012, Oscar was spoken to by police as a result of a verbal argument with a tenant of a property owned by him over rent. No further action was taken in respect of this. Finally, in 2013, Oscar reported his concerns for the children a result of Denise s behaviour. He described her staying in bed and drinking all day, driving them about when drunk and was concerned for their safety. The police dealt with this jointly with the County's Children's Services.

r) Contact between the County's Children's Services provision and the family was limited to that one occasion in 2013 where they jointly dealt with Oscar's referral to the police.

s) The children were all educated within the County's maintained schooling system. None of the schools felt it necessary to raise any safeguarding concerns with Children's Services. There was a limited knowledge within the schools of the circumstances under which the children were living in the months and years leading up to the tragedy.

t) The County's Court Services became involved in 2013 when Oscar applied to the family Court for a Residential and Prohibited Steps Order. The Court requested the Children and Families Court Advisory and Support Service (CAFCASS) advise them and they became involved on three separate occasions; November 2013, May 2014 continuing through to October 2014. CAFCASS officers interviewed all of the family at a Family Assessment Day in October 2014 and their report was being prepared at the time of the deaths.

Section 2: Key issues arising from this Review

2.1 This is a particularly harrowing case to Review, not least because it shows the difficulty in reasonably predicting human behaviour, in particular those who are suffering acute stress and mental ill-health. Oscar was rightly identified as posing a genuine risk of suicide and those charged with care did what they could reasonably have been expected to do to mitigate that risk. There was no recognition of the threat he posed to Denise; largely because it was not considered that he posed such a risk; the Review does not consider that in this case that was unreasonable.

2.2 There were opportunities to better share information which may have afforded some additional help to the family whilst they were undergoing the stress and anxiety of an acrimonious divorce. This Review does not suggest that the level of information that could have been shared would or could have prevented the tragic events that occurred; we will never know.

2.3 The Courts operate, rightly, independently of other agencies. Court Orders were made in this case to prevent Denise from removing the children away from the area, or indeed out of the Country. Those Orders are not routinely brought to the attention of other local safeguarding agencies, including the schools that protect the children for a significant proportion of their childhood. This Review feels that when Courts make such orders, steps are taken to put in place a process to alert those responsible for the care of young people (including the schools), wherever possible, as to the context of such Orders. Each school has nominated safeguarding leads who can take steps to protect the integrity of such information.

2.4 Two children in this case attended school with injuries that we now know were caused by their mother. The school embarked upon enquiries as to how those injuries occurred and, not satisfied by their response, called both parents as to an explanation. Both parents lied to protect Denise, saying they had been fighting. The school reasonably accepted that explanation but made enduring record of the injuries and the incident was not shared. When officers from another agency were informed about the same incident by Oscar and the children they felt it historic, had been dealt with and did not share it. This issue shows the need for information to be recorded and shared as it could have been recognised that the two accounts did not accord with each other.

2.5 Whilst there was a very strong level of readily available family support to the children and to Oscar in Denise's absence, the Review felt it is likely that many families and children going through the pressures of domestic abuse, divorce and family breakdown will not have similar levels of support that were prevalent within the wider family in this case.

2.6 There were some procedural misunderstandings that existed between Oscar's GPs and the mental health provider. It is clear that the expectations and understanding of the GPs and The NHS Foundation Trust as to what constituted an urgent referral were at odds on this occasion. This Review would suggest that any existing protocol that exists between GPs and The Trust for emergency referrals be reviewed and clarity communicated about expectations. The Trust did not deal with this issue with the urgency that the GPs expected and thus an opportunity to engage with Oscar on the day of crisis was lost. However, the Trust asserts that they adhered to the protocol for an urgent referral. There is need for clarity of the process.

2.7 The Children and Families Court Advisory Support Service have a vital safeguarding role to play when appointed by the Courts to advise them. At present they can only assist such Reviews when authorised by the Judge so to do. In this case the Judge gave such authorisation but the Review feels that they play such a central role in safeguarding that in cases where they are involved they should be a statutory member of the panel, in the same way that others charged with safeguarding the vulnerable are.

Section 3: Conclusion

3.1 This was a truly tragic case resulting in two untimely deaths and orphaned children.

3.2 Whilst there was some prior service involvement with the deceased this was largely within the domain of the health services. The services provided by them were largely proportionate and escalated appropriately in a timely manner. Whilst there were significant indications to them that Oscar was a clear suicide risk, they were not made aware of any threat that he posed to Denise. In addition, it is not reasonable to conclude they should have been identified such a threat.

3.3 Other agencies had more limited involvement, the police and County's Children's Services departments had minimal knowledge of either of the deceased and the one specific referral they received from Oscar they shared and responded to appropriately at the time.

3.4 The County's schools provided a caring environment for the children, however, the schools could have made a safeguarding referral when two children arrived at school with significant injuries to their faces, which we now know were caused by their mother. The schools embarked upon an investigation and were satisfied with the explanation they received from both parents who lied to them. The fact that they did not make a referral is understandable and was in accordance with existing practice. The fact that no record was made of the incident by either school is regrettable but also in line with what was existing practice.

3.5 The Court engaged CAFCASS to provide them with an assessment of safeguarding issues in this case. CAFCASS had three opportunities to make referrals based upon information provided to them from the family, in particular the children. None were made. This Review acknowledges that decisions as to safeguarding referrals should not be made lightly and are a professionally subjective decision affected by many more factors than are available to us in hindsight. However, it does feel on balance that referrals should have been made in this case.

3.6 This is a case that once again highlights the stigma that still exists in relation to mental ill-health. The father, prone to stress and anxiety, felt he could not tell those who were charged with making decisions about the long term care of his children, for fear of it being held against him.

3.7 As with many cases, some decisions could have been made differently. There are lessons to be learned and this Review has identified a number of recommendations for further action in order to try and prevent anything similar. There were opportunities for referrals or information sharing across agencies that may have prompted an intervention and additional support for a family in crisis. There is no way of knowing whether such intervention would have prevented what happened; it may have done but equally it may have only hastened the same tragic end.

3.8 Our thoughts are with the surviving children.

Section 4: Recommendations

Recommendation 1: Any existing protocol that exists between GPs and The NHS Foundation Trust for emergency referrals be reviewed and clarity communicated about expectations.

Recommendation 2: That the Local Safeguarding Children's Board take steps to ensure that the range of support available is clear to all professionals who engage in work with children and families.

Recommendation 3: That the Local Children's Safeguarding Board work in partnership with the County's Education Department, Children and Young People's Services (C&YPS), the Courts and CAFCASS to review current processes in relation to Court Orders so that it properly supports the children and closes any potential safeguarding gaps.

Recommendation 4: That the Local Children's Safeguarding Board work with the local Education Authority to review the policy about recording of incidents such as this within its schools with a view to ensuring all unexplained injuries are recorded and what steps are taken to seek explanation.

Recommendation 5: That CAFCASS reviews its working practice to ensure that all staff completing assessments have adequate levels of quality assurance.

Recommendation 6: That the Home Office consider adding CAFCASS as a statutory body within the meaning of the Act.

Recommendation 7: That a clear County-wide partnership governance structure be established for the strategic leadership of domestic abuse within Suffolk.