Domestic Homicide Review

-Executive Summary-

Commissioned by

London Borough of Hackney

Victim: “Jane”

Died: April 2014

Independent Chair

& Report Author: Stephen Roberts QPM, MA(Cantab)

Completed: 23rd August 2017
Executive Summary

1. The Review Process

1.1 This summary outlines the process undertaken by the Hackney Community Safety Partnership domestic homicide review panel in reviewing the death of a woman who was resident in its area.

1.2 The following pseudonyms have been for the victim, perpetrator and other parties in this review to protect their identities:

Victim: JANE aged 61. White, British, with no known religious affiliations.

Perpetrator JOHN aged 68. Black - Afro-Caribbean, British with no known religious affiliations.

Adult children of Jane & JOHN: K & L

Personal friend of JANE: Z

1.3 Criminal proceedings were completed on 19th April 2016. The perpetrator was found guilty of murder and sentenced to life imprisonment with a minimum sentence of 19 years before he could be considered for parole.

1.4 An executive decision to conduct a review was taken immediately after the homicide and the review process began on 26th April 2014 with an initial meeting of those agencies known to have contact with JANE and/or JOHN. All agencies that potentially had contact with either JANE or JOHN prior to the point of death were contacted and asked to confirm whether they had actual involvement.
1.5 Four of the six agencies contacted confirmed contact with the victim and /or perpetrator and were asked to secure their files.

2. Contributors to the Review

2.1 No Individual Management Reviews (IMR) were requested because no agency held sufficient information to make such an exercise meaningful. The following agencies were asked to participate in the review process:

The Metropolitan Police (MPS)
London Borough of Hackney (LBH), Adult Social Services
LBH Domestic Violence & Abuse Team
LBH Human Resources Department
NIA (a provider of IDVA Services for Hackney)
Clinical Commissioning Group (CCG)

2.2 The MPS granted access to the evidence gathered by its homicide investigation team at various stages of the review. This enabled a more detailed picture to emerge of the background to the tragedy than might otherwise have been possible.

2.3 The following documentary evidence was provided by various agencies to the review:

MPS – A formal letter summarising the incident and background from the police perspective together with relevant witness statements and expert reports derived from the criminal investigation.

Clinical Commissioning Group – Copies of NHS records for JANE and JOHN.
LBH Human Resources Dept – HR records relating to JANE

2.4 JANE and JOHN had two adult children; K (male) and L (female). At the start of this review the Independent Chair wrote to K explaining the process and inviting him to become involved. Despite repeated requests, he did not engage with the process. L has autism and severe learning disabilities. Her condition is such that she was and remains incapable of understanding even that her mother is dead.

2.5 In a further effort to identify the underlying causes of the tragedy, the author of this report attended the trial of JOHN at the Central Criminal Court in order to hear the evidence in the case, obtain a copy of the Pre Sentence Report and to note the judge’s remarks.

2.6 At JOHN’s trial, two of JANE’s work colleagues and friends gave evidence that she had spoken of her difficulties with her husband. As part of the review, the Independent Chair interviewed both women. In addition, the Independent Chair obtained the formal written statement provided by JANE’s friend, Z, and after some considerable delay, was able to interview him. Their platonic relationship was discovered by JOHN after which it appears his abuse of JANE escalated. Z was able to give additional background and perspective. The contributions and perspectives of all three have been incorporated into this review.

2.7 Due to his medical condition, JOHN was unfit to be interviewed by the Independent Chair for some time after his trial. This meeting finally took place in July 2016. Material from that interview has been incorporated into this report.
3. **The Review Panel Members**

3.1 The Review Panel consisted of the following members:

Stephen Roberts, QPM, MA (Cantab) – Independent Chair

Steve Bending, Acting Head of Safer Communities, LBH

Cathal Ryan, Interim Domestic Violence Transformation Manager, LBH

Ch. Supt. Simon Laurence, MPS Borough Commander, Hackney

Det. Ch. Insp. Catherine Edgington, MPS Crime Manager, Hackney

Lorraine Robinson, Dir. Of Human Resources, LBH

Rob Blackstone, Dir. Adult Services, LBH

Karen Ingala-Smith, NIA Domestic Abuse charity & IDVA provider

DS Janice Cawley, MPS Serious Crime Review Group

The work of the panel was overseen by Councillor Sophie Linden, Deputy Mayor with responsibility for community safety.

3.2 No member of the Panel had direct responsibility for JANE in her employment with LBH. Neither NIA, an IDVA provider, nor LBH’s own Domestic Violence & Abuse Team had any contact with JANE.

3.3 The Review Panel met on four occasions: 20\(^{th}\) June 2014, 12\(^{th}\) June 2015 and 20\(^{th}\) July 2016. The Panel gave final approval of the Overview Report and Executive Summary on 28\(^{th}\) November 2016.
4. **Independent Chair & Report Author**

4.1 Stephen Roberts, QPM, MA, was appointed by the Hackney Safer Communities Partnership as Independent Chair of the Review Panel and Report Author. He is a former Deputy Assistant Commissioner of the Metropolitan Police, now working as a private consultant. He has extensive experience of partnership working at borough and pan-London level. He is a former Director of Professional Standards and Director of Training & Development for the Metropolitan Police. He is entirely independent of the Safer Communities Partnership and all other agencies involved in this review. He has completed training for the role and has successfully chaired and authored domestic homicide reviews for this and other Community Safety Partnerships.

5. **Terms of Reference for the Review**

5.1 The review was guided by the following terms of reference:

- To establish what lessons may be learned from the case regarding ways in which local professionals and agencies worked individually and collectively to safeguard victims.

- To determine how those lessons may be acted upon.

- To examine and where possible make recommendations to improve risk management mechanisms within and between all relevant agencies.

- To identify what may be expected to change and within what timescales.

- To assess whether the relevant agencies have appropriate and sufficiently robust procedures and protocols in place and the extent to which they are understood and adhered to by their
staff, including an examination of the metrics and management information mechanisms in relation to risk assessment and management.

- To improve service responses including, where necessary, changes to policies, procedures and protocols.

- To enhance the overall effectiveness of efforts to reduce domestic violence and its impact on victims through improved inter and intra agency working.

- To maximise opportunities for fast time learning and overall partnership improvements as well as medium and longer term enhancements.

6. **Summary Chronology**

6.1 Neither JANE nor JOHN had come to the notice of the relevant agencies in the context of domestic abuse. JANE was employed by LBH in the “Meals on Wheels” service.

6.2 JOHN and JANE were an established couple but not legally married. They had a son (K) together in 1985 and a daughter (L) in 1987. With the exception of L, the family lived in a three bedroom flat in Hackney which JANE and JOHN had purchased jointly from Hackney Council in 1992. L suffers from autism and severe learning difficulties and resides permanently in a care home provided by LBH. JANE was a frequent visitor to her daughter’s care home although JOHN never accompanied her.

6.3 At the time of the murder, JOHN was 67 years old and employed as a crane operator. He had criminal convictions for robbery and burglary for which he had served terms of imprisonment. The first of these was a robbery in 1963. He was subsequently
convicted of an unconnected burglary in 1970. In view of the fact that the latter offence occurred some 44 years before the murder, his criminal history cannot be considered relevant to this review. Nothing was discovered by the MPS to illuminate the provenance of JOHN’s unlicensed shotgun or to suggest its previous use in crime. Several years before the incident, JOHN had undergone extensive surgical cancer treatment and required continuing medication for his condition. In the months preceding the killing, he had started to consume increasing quantities of alcohol even though this conflicted with the prescribed medicines.

6.4 Two of JANE’s work colleagues described her as a happy, extrovert person. She had worked for LBH for 15 years and was described by her supervisor as a happy, laughing and reliable worker. She had disclosed that she was unhappy in her relationship with JOHN and that they had agreed to separate. After they had agreed, JOHN had asked to stay in their flat, albeit with the two of them sleeping in different rooms. Apparently JANE had made it very clear that she felt that she should retain their flat once the couple had actually separated. The colleagues recall that, within a few months of her death, JANE had told them that JOHN had grabbed her around the neck and they remember seeing the bruises and advising her to tell the police. She also disclosed that she believed JOHN had tried to damage the brakes on her car. One of JANE’s colleagues who was last to see her alive, recalls that on the night of her death, JANE appeared reluctant to leave work to go home.

6.4 JOHN’s account of the state of his relationship with JANE is that “things started to go a bit funny” as a result of his illness and surgery. The police investigation indicates that from at least late 2013/early 2014, JOHN had become suspicious of his wife’s
behaviour and they had agreed to sleep in different rooms. They also agreed that they should separate and divide their joint money.

6.5 JANE’s mobile phone records show that as early as November 2013, JANE had been exchanging affectionate messages with a male friend, Z. These continued until the day before the murder. Z acknowledged that he and JANE had become friends and in the summer of 2013 had enjoyed a holiday together. He also acknowledged that JANE had transferred money from her bank account to his. The money was his and JANE had merely assisted in its international transfer. Z emphasised that he and JANE were friends and that there had never been a sexual relationship between them. Z described JANE as “a very nice and happy person”. She had told him that her relationship with JOHN had become very difficult, not least because JOHN was frequently drunk, bad-tempered and rude. She told Z that despite these problems, she was happy to stay with JOHN, albeit she was often reluctant to go home and instead of returning there after work would spend time with friends elsewhere. JANE never spoke to Z about any violence in the relationship.

6.6 Family money matters were handled by JANE but by March 2014, JOHN had searched for and found statements from their joint account, indicating that JANE had transferred significant sums of money to a Moroccan bank account. This and other discoveries fuelled his suspicions that not only was JANE meeting other men but that she was also siphoning money from the account to which he contributed his earnings and on which he relied for his retirement. At about this time, JANE told a colleague that JOHN had grabbed her by the scruff of her neck and only released her when her son K intervened. Thus by March 2014 it appears that JOHN’s abuse of JANE had escalated significantly.
6.7 JOHN shared his suspicions with his son, K, and asked him to help by examining JANE’s e-mail contacts. He also asked K to download material from JANE’s laptop computer onto a memory stick. Examination of this memory stick by police revealed a number of images of JANE on holiday and of a female’s exposed cleavage. The images do not show the head of the female but are believed by police to depict JANE. On the same memory stick were copies of money transfer paperwork and documents relating to Z.

6.8 On 7th April 2014 JOHN, accompanied by his son, sought advice from a firm of solicitors on his legal position and what to do about the money in the joint account. Subsequently he withdrew £9000 and a further £10,000 from the account and transferred it to K’s account where he believed it would be “safe”.

6.9 JOHN owned an unlicensed shotgun. In early April 2014 he searched the flat for the gun and asked JANE where it might be. On the night before her murder, JANE remarked to her work colleague that JOHN had been looking for the gun and “maybe he wants to shoot me with it.” Her colleague asked JANE if she was serious but received what she regarded as a flippant reply, “Nah, I’m going home.” And later quipped “Goodbye and if I’m not in Friday, I might be dead.”

6.10 On 9th April 2014 K overheard his parents arguing. He recalls that he heard his mother say “Mention one more word about the money and the affair and I will go.” Later that evening JOHN invited his son to go to the pub with him the following Saturday. He told K that he planned to make financial provision for his children then retire to Antigua.
6.11 On 10th April 2014, JOHN gave his son several hundred pounds which he said he no longer needed and the address of K’s aunt in Antigua.

6.12 At 04.55 on 11th April 2014, a call was received on the 999 system from JOHN in which he stated “There’s a couple of bodies at [address].” When police forced entry they discovered the decapitated lifeless body of JANE on a plastic sheet. Scattered around the body were documents relating to Z and receipts showing cash deposits from JANE to a Moroccan bank account in the name of Z.

6.13 JOHN pleaded guilty to manslaughter but not guilty to the murder of JANE. The Crown declined to accept his plea of guilty. At his trial JOHN claimed that he had not intended to kill his wife and that he “only meant to slap her about a bit” adding that he “tapped her on the head [with a metal bar] to get her attention.” He was convicted of murder on 7th April 2016.

6.14 In sentencing JOHN, the Recorder of London, His Honour Nicholas Hilliard remarked:

“I’m sure you don’t regret your wife’s death save for the effect on your own comfort and wellbeing.”

JOHN was sentenced to life imprisonment with the condition that he must serve a minimum sentence of 19 years before he could be considered for parole.

7. **Key Issues Arising from the Review**

7.1 There was no information available to the MARAC in relation to domestic abuse between JOHN and JANE. As a supplement to this review LBH commissioned an independent review of the effectiveness and efficiency of the MARAC. The MARAC review...
takes account of the current implementation programme resulting from the recommendations of several previous DHR. This review does not, therefore, examine the functioning of the domestic abuse systems and capabilities beyond the precise boundaries of this particular homicide.

7.2 It is evident from the case history that for some months before the incident, JOHN’s behaviour had worsened to the point at which JANE decided she could no longer accept it and the couple decided they should separate: initially simply to separate bedrooms but with the ultimate intention of a full separation. Although the couple had significant savings, both were understandably concerned to retain possession or at least ownership of their jointly owned flat. JOHN also worried about the security of the money he had saved for his retirement. What appears initially to have been a largely consensual decision to separate deteriorated as JOHN became suspicious of JANE’s relationships outside the home and increasingly concerned about the transfers of money from their joint account.

7.3 It must be a matter of speculation but it seems likely that JANE had at least some concerns for her personal safety. The case history includes clear evidence of escalating levels of violence, especially from about March 2014. At about this time, there is also limited evidence of JOHN’s attempt at coercive control – specifically his attempt to take control of their joint finances and the fact that he persuaded his son, K to hold money on his behalf but also to seek access to JANE’s computer in search of “evidence” of her activities. JANE had told colleagues of the difficulties in her relationship with JOHN. Her references to being killed appeared flippant at the time, but subsequent events, as well as the fact that she had shown colleagues the bruises around her neck, suggest that, at the very least, JANE had become increasingly cautious about going home after work due to JOHN’s behaviour.
7.4 Despite the violence JANE had suffered and the escalating tensions between the couple, JANE did not seek active support from any agency or indeed her manager within LBH. There is ample research demonstrating that many women who find themselves in such a vulnerable position, nevertheless do not seek help because of a range of inhibiting factors. NIA (the Domestic Abuse charity) describes the principal factors in the following terms:

“shame, feeling it’s their own fault, not wanting to admit there’s a problem, feeling exhausted and demoralised by the abuse and not being able to face telling a stranger about it, feeling judged, feeling more afraid of the unknown future than the known present or past.”

7.5 It appears that JANE only confided her problems to her close friends at work. In interview those colleagues clearly regretted the fact that they had respected JANE’s confidences. It is at least possible that had JANE or her colleagues had a better understanding of the problems of domestic abuse and the main risk factors, they might have sought advice from their manager and thus initiated support. The likelihood of such an outcome would have been increased had there been an established policy for dealing with such matters and awareness among staff of its existence. It is for this specific reason that the Action Plan focuses on work with staff to increase awareness of domestic abuse and what actions they should consider if they become aware of it from colleagues, or indeed if they themselves fall victim.

7.6 At the very beginning of this review it was identified that LBH gave no specific guidance to staff or managers concerning domestic abuse even though it has a duty to respond appropriately to concerns about staff welfare and safety. In respect of domestic abuse, the need was identified for simple step by step guidance for managers
about recognising and responding to victims of abuse. In interviews with LBH employees, it was quite evident that the very fact of JANE’s murder has focused the minds of managers and employees on the subject of domestic abuse. The new guidance, together with its implementation plan will embed and sustain this awareness for the future. The guidance document is attached at Appendix A to the Overview Report. The Action Plan outlines the steps for its implementation and consolidation within LBH as part of its HR policy. The guidance will sit alongside the borough Violence Against Women & Girls Strategy.

8. Conclusions

8.1 The psychological phenomenon known as “outcome (or hindsight) bias” is a common feature of the way in which those analysing a sequence of events allow their knowledge of the outcome to influence their beliefs about the correctness of decisions prior to that crisis point. The phenomenon might be expected to apply with particular force in a case such as this, where a death has occurred. In this case, JN’s prophetic words to her colleagues as she left work for the final time may all too easily leave those colleagues feeling that they should have done more to support her. Such a conclusion would be entirely wrong. JANE’s apparently flippant attitude to her situation may have concealed genuine concerns for her welfare but any such concerns could only have been explored through caring and sensitive discussions with an appropriately trained and supported supervisor. The new workplace guidance aims to provide the tools and sensitivities for managers and supervisors and to embed the approach within HR policy and the Violence Against Women & Girls Strategy. This review therefore makes only a single recommendation.
9. **Lessons to be Learned**

9.1 This case illustrates the fact that people (principally women) who are subject to domestic abuse commonly do not report it or seek help. This may arise from their failure to perceive their treatment as abuse and/or a lack of understanding of the factors which may be escalating their risks. Even where abuse is recognised, there are additional factors inhibiting disclosure. Recognition of these factors is not, in any sense, an attempt to blame victims for their fate – rather it points to the issues which any effort to reduce abuse must address. The guidance now implemented by LBH seeks to increase awareness and thereby support its staff in such difficulties.

10. **Recommendation**

10.1 The “Domestic Abuse & Workplace Guidance for Managers and Employees” to be implemented as specified in the Action Plan. (Independent Chair’s note: the plan was completed in December 2016 and passed its 6 month review process in June 2017).

*Stephen Roberts QPM, MA (Cantab)*

*Independent Chair & Report Author*