Safer Plymouth

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

Under s9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of 'Missy' in December 2013

report produced by Independent Chair
Dr Jane Monckton Smith

October 2019

Restricted / Official Sensitive

Glossary

- AAFDA - Advocacy After Fatal Domestic Abuse
- CPS - Crown Prosecution Service
- CSP - Community Safety Partnership
- DASH - Domestic Abuse, Stalking and 'Honour'-Based Violence Risk Identification
- DHR - Domestic Homicide Review
- DVPP - Domestic Violence Perpetrator Programme
- FLO - Family Liaison Officer
- FOIA - Freedom of Information Act
- GMPS - Government Protective Marking Scheme
- IDVA - Independent Domestic Violence Adviser
- IMR - Individual Management Reviews
- MARAC - Multi-Agency Risk Assessment Conference
- PCT - Primary Care Trust
- SHA - Strategic Health Authorities
- SIO - Senior Investigating Officer
- SMART - Specific, Measurable, Achievable, Realistic and Timely
- TOR - Terms of Reference

List of Contents

Preface

I would like to begin this report by expressing my sincere sympathies, and that of the panel, with the family and friends of Missy who is remembered universally as a kind, gentle and fun-loving person who is keenly missed. She was very popular and in her place of work there is a memorial to remember the caring and innovative work she did for vulnerable and bullied children. This gives some insight into the way that Missy lived her life and is remembered. She leaves behind a child who has suffered the ultimate in loss, but despite this trauma, is a credit to Missy and her family.

The purpose of a Domestic Homicide Review (DHR) is to identify improvements which could be made to community and organisational responses to victims of domestic abuse, and hopefully to try and prevent a tragedy like this from ever happening again. This report examines agency responses and support given to Missy, a resident of Plymouth prior to the point of her death in December 2013. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer and summarise the circumstances that led to a review being undertaken in this case.

I would like to thank the panel, and those who provided chronologies and information, for their time, patience and co-operation. I would also like to thank Missy's family for welcoming me into their home and speaking to me about Missy and her relationship with them and Alf.

The name Missy is a pseudonym decided upon by the family. Alf (the perpetrator) and Marie (his former partner) are names decided upon by the Independent Chair. Missy's child will simply be referred to as a child so as not to identify them.

Jane Monckton Smith
Independent Chair

The Review Process

This review was commissioned by Safer Plymouth on behalf of Plymouth City Council in response to the death of Missy in December 2013. The review followed the key processes outlined in the Home Office Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016).

The decision on whether to hold a review was taken by the Chair of Safer Plymouth within one month of the homicide of Missy coming to their attention and it was decided a review was unnecessary. This decision was reversed after an intervention from AAFDA on behalf of the family in June 2015, and it was finally decided, by the Chair of Safer Plymouth, to hold a review in June 2015.

The Home Office was informed of the decision to conduct a DHR.

The first panel meeting was held on 17th July 2015 with the first Independent Chair.
Due to unforeseen circumstances the first Chair had to resign and the DHR was pended whilst a replacement was found.

Dr Monckton Smith was appointed in November 2015.

The inquest was adjourned in April 2016 and will not resume.

Some further delays have occurred in this case the most time consuming of which was waiting for the completion and sight of an IPCC report. Devon and Cornwall police would not allow sight of their IMR or any information until this was completed.
The first panel meeting with Dr Monckton Smith was in January 2016 and the Terms of Reference were discussed and drafted.

Communication with the family was done through a specialist AAFDA advocate.
The Chair met with the family four times and provided regular updates to them via the AAFDA advocate.

The panel met on four occasions. An offer to meet the panel was extended to the family but they felt unable to attend.

The Chair met with the family and the police and an IPCC representative in April 2017 when it was decided that the police would give a face to face apology to Missy's family.

The family were given the draft report and invited to comment and contribute, which they did at a meeting with the Chair in April 2018.

A final draft was produced in June 2018.

All final comments and contributions from the family, which took some time, were recorded in January 2019 via the AAFDA advocate.

The report and executive summary was submitted to Safer Plymouth in October 2019.

Contributors to the Review

- General Practitioner of Missy
- Devon and Cornwall Constabulary
- Family members
- Missy's child's school

The Review Panel Members

Dr Jane Monckton Smith – Independent Chair

Chloe Webber	Serious Case Review, Public Protection Unit, Devon and Cornwall Police
Kerri-Ann Alee	Senior Probation Officer, Devon and Cornwall Probation Trust, Safeguarding Champion
Jason Preece	Plymouth Domestic Abuse Services
Katy Bradshaw	Plymouth Domestic Abuse Services
Gillian Scoble	Safeguarding Nurse Primary Care, NEW Devon CCG (Northern, Eastern and Western Devon Clinical Commissioning Group)
Jo Brancher	Safeguarding Adults Operational Manager Plymouth Hospitals NHS Trust
Gary Wallace	Senior Specialist Drugs and Alcohol Team Manager, Office of the Director of Public Health.

None of the Panel members had direct involvement in the case nor had line management responsibility for any of those involved.

The administration of the DHR was supported by Dr Jane Monckton Smith's personal assistant, Sue Haile. Sue is also an employee of AAFDA but was not involved with this case in that capacity, ensuring no conflict of interest.

Author of the Overview Report

Dr Jane Monckton Smith was appointed by Safer Plymouth as the independent chair and author of the Overview Report in November 2015. Jane is a forensic criminologist who specialises in domestic homicide and works for the University of Gloucestershire. She has published research on domestic homicide and trains professionals in domestic abuse risk assessment as well as working with a number of stalking and domestic abuse and homicide charities. Publications include:

Monckton Smith, J. (2019) Using Foucauldian Analysis to Track and Eight Stage Progression to Homicide Violence Against Women v26 i11 https://journals.sagepub.com/doi/metrics/10.1177/1077801219863876

Monckton Smith, J., Szymanska, K. and Haile, S. (2017) Exploring the Relationship Between Stalking and Homicide Suzy Lamplugh Trust

Monckton-Smith, J. (2015) Turning Abuse Upside Down Safe Domestic Abuse Quarterly Women's Aid Federation

Monckton-Smith, J. and Williams, A. with Mullane, F. (2014) Domestic Abuse, Homicide and Gender: strategies for policy and practice Hampshire: Palgrave Macmillan

Mawby, R.I. and Monckton Smith, J. (2013) Catching criminals or helping victims? in Bruinsma, G. and Weisburd, D. (eds) Encyclopedia of Criminology and Criminal Justice Springer

Monckton-Smith, J., Hart, A., Newberry, J. and Adams, T. (2013) Introducing Forensic and Criminal Investigation London: Sage

Monckton-Smith, J. (2012) Murder, Gender and the Media: Narratives of Dangerous Love Hampshire: Palgrave Macmillan

Monckton-Smith. J. (2011) The Paradox of Cinematic Sexual Violence as Entertainment in Mawby, R.I., Barclay, E. and Jones, C. (eds) The Problem of Pleasure London: Routledge

Monckton-Smith, J. (2010) Relating Rape and Murder: Narratives of Sex, Death and Gender Hampshire: Palgrave Macmillan

Jane is independent of any of the agencies or organisations in Plymouth and has no previous involvement with Safer Plymouth nor any of the agencies involved in the domestic homicide review into the death of Missy. She can evidence that she has advanced knowledge of domestic abuse and coercive control as stipulated in the updated Home Office guidance for conducting DHRs, 2016.

Terms of Reference

Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The act states that a DHR should be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —

> *(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
> *(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'*

Missy had been in an intimate relationship with Alf for approximately 3.5 years. Their relationship ended in November 2013. Safer Plymouth commissioned a DHR in accordance with *a)* above. The purpose of the Review is to:

1. Establish the facts that led to the events in December 2013 and whether there are lessons to be learned from the case about the way in which local professionals and agencies carried out their responsibilities and duties, and worked individually and together to safeguard Missy (victim), Alf (perpetrator) and Missy's child.

2. 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.

3. Apply any learning to the policy, procedures and practice of individual agencies and inter-agency working locally and to inform national policy and practice where appropriate. This will include;
4. Highlight any identified good practice.

5. Prevent domestic abuse and homicide and improve service responses for all victims, including children, by developing coordinated multi-agency approaches to identify and respond to domestic abuse at the earliest opportunity.

6. Contribute to a better understanding of the nature of domestic violence and abuse.

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

7. The review will address whether agencies that had contact with the victim, her child or the perpetrator could have done more to recognize signs of abuse and signpost to suitable support.

8. To seek to involve family including child, friends, key workers, colleagues and any other person who had significant contact, to participate in the review so that we can better understand the victims experience and establish whether there were any barriers in the victim or family reporting abuse or accessing interventions that might have helped.

9. To establish whether the perpetrator had any previous concerning conduct or a history of abusive behaviour to an intimate partner and whether this was known to any agencies.

10. To give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator or family members.

11. To consider any other information that is found to be relevant.

Summary of events and Key Issues arising from the Review

1. Missy lived in Plymouth and was killed in her home by Alf who was a former partner. Alf lived with Missy and her child for around three and a half years. Alf had a history of domestic abuse and stalking and became involved with Missy not long after the break-up of his marriage where he abused and stalked his former partner. There is an allegation that Alf broke into his ex-wife's home in the middle of the night and attempted to strangle her. Missy knew of some allegations of abuse made by Marie, the ex-wife, but did not believe they were true.
2. During the relationship there is evidence to suggest coercive and controlling behaviour, and a clear escalation in concerning behaviours, including stalking, when Missy attempted to separate from Alf. This mirrored his behaviour from the previous relationship.
3. In this case there was little agency involvement over the course of the relationship, but there were a number of opportunities for intervention when Missy requested help after the separation. There were also many missed opportunities in Alf's past which impacted on the predicament Missy found herself in. The opportunities to help Missy largely revolved around knowledge and understanding of the threat to her from Alf. Dangerous patterns which are common in domestic abuse when separation occurs were not recognised, had they been recognised there may have been more effective intervention.
4. Police had the relevant information that a dangerous pattern of abuse existed from what was recorded of Alf's history in their databases. They had access to information which warned that Alf was violent, and a high-risk abuser. A risk assessment interview was completed, and relevant information about Alf was gathered. Not all the information about Missy's fears was recorded. Much of the detail appeared to come out in the murder investigation. This information was however, in the possession of the officer receiving it, and could have helped inform the officer completing the risk interview and subsequent police response.
5. Family and friends of Missy did not like Alf, and Missy's friends identified him as a stalker. Alf's friends were aware that he was not accepting the end of the relationship and was gaining illegal entry to her home with a key she was unaware he had. They did not inform Missy, or the police of this before her death.
6. Missy made it very clear to Alf that the relationship was over. She had a friendship which may have been developing into a new relationship, and which she hid from him through fear of how he would respond.
7. Alf broke into Missy's home in the middle of the night, mirroring previous behaviours. Missy attempted to get help by calling 999 when she discovered Alf in her home, but because she did not speak directly into the phone, her call was put through to an automated system and no police attended because of this.
8. Whilst her child was upstairs sleeping Alf strangled Missy. He sat with Missy's body until the following morning when he called the police to say what he had done.
9. Missy's child was upstairs the whole time. In the morning they saw their mother's body underneath a duvet and were told by Alf that she was sleeping.
10. Alf was charged with murder and convicted in July 2014 and received a life sentence with a tariff of 22 years reduced to 17.5 years for a guilty plea.

Conclusions

It can be concluded that there was enough known about Alf to suggest he was a danger to Missy. There were also opportunities to provide Missy with safety advice; enhanced resources (from a high risk of harm assessment) and information about Alf which may have helped her understand the risk he presented to her.

Given the information taken from friends and family it can be reasonably assumed that Missy was a victim of coercive control domestic abuse. Even though coercive control was not considered a criminal pattern at the time, its dangerousness and links to homicide were acknowledged and included in standard risk assessment checklists used by Devon and Cornwall Police.

There was enough information to identify a pattern of stalking and escalating risk.
The information held by police showed a history of abuse, as well as stalking, so revealing a pattern.

The police did not know that Alf had a key to Missy's home, but this should always be assumed in safety planning where the perpetrator has previously lived in the premises.

The police should have known about operation of the silent system.
Improvements could be made to the operation of the silent system for victims.
This leads to the conclusion that improved leadership in domestic abuse and stalking responses, professional knowledge, and public knowledge are strongly indicated as key learning opportunities.

Learning Opportunities

Learning Opportunity 1

Devon and Cornwall Police identified that PCSOs should receive training in domestic abuse and stalking in their initial training package. PCSOs are often the first officers to receive such complaints and to interview victims. Consequently, they need to be fully aware of the potential risks to victims.

Learning Opportunity 2

Devon and Cornwall Police recognized a need for disclosures or reports of stalking to be reviewed by senior officers, both duty Inspectors and Control Room Sergeants. A review of such disclosures gives a second line of knowledge to the reported incident and reduces the risk of high risk cases slipping through the net. We would suggest in addition that officers are actively encouraged by senior officers and domestic abuse and stalking leads and champions to seek specialist guidance and support when taking disclosures of domestic abuse and stalking if they are at all concerned.

Learning Opportunity 3

Devon and Cornwall Police identified that thorough checks were not done in this case and should be done on the history of alleged offenders/perpetrators in all cases. The information was available to officers.

Learning Opportunity 4

Devon and Cornwall Police recognized that refresher training is required on domestic abuse and stalking. Despite having rolled out comprehensive training to frontline officers, there appeared to be a lack of understanding around the risks posed by stalkers, especially former partner stalkers.

Learning Opportunity 5

Devon and Cornwall Police identified a need for initial and refresher training to be included in a wider safeguarding training plan, thus giving domestic abuse and stalking strong strategic status.

Learning Opportunity 6

This review notes that awareness of the prevalence of domestic abuse and stalking is not sufficient for professionals working on the frontline, or for more senior leadership roles. Training packages should be scrutinized so that officers and training staff receive adequate tools to respond effectively to disclosures. If officers were equipped not only to recognize, but respond to, domestic abuse and stalking, this would have been helpful to Missy in this case. A clear need for officers to be aware of safety planning options, to understand safety options already in place, and understand victim fear and offender persistence is identified. It is also crucial that officers in detective roles are equally well trained. Domestic abuse is not confined to low level offending, it is implicated in the most serious offending, and in this case a homicide. The decisions and lack of knowledge of a detective impacted on a poor decision made about Alf's dangerous behaviours in the history of this case.

Learning Opportunity 7

Missy did not recognize the importance of Alf's previous behaviour. There are processes in place which could have been operationalized to help her to understand the risk posed by Alf. A Clare's Law disclosure with proper support may have helped her understand. This would have created an opportunity to talk to Missy about the dangers of allowing access.

Learning Opportunity 8

Alf's friends did not recognize the dangers in his behaviours. If there was more public knowledge around the dangers of stalking and domestic abuse after a separation, Alf's friends may have taken some sort of action and informed police or Missy about his actions.

Learning Opportunity 9

Throughout Alf's history he was not seriously sanctioned for his behaviour. He was able to manipulate others to believing he was the victim. Seriously high risk behaviours were demonstrated which revealed his potential for homicide. This panel recommends

that it is important that offenders are consistently challenged, and that meticulous evidence gathering should accompany all potential prosecution attempts.

Learning Opportunity 10

The Homesafe team could have been crucial in this case as they may have been able to encourage Missy to change the locks on her house.

Learning Opportunity 11

It is known that Missy's child was frightened, especially when the stalking started. The child was also concerned about Alf's behaviours in the home. Pastoral care, and support and guidance from the school may have encouraged the child to seek support or to disclose their concerns. A recommendation around school support could also include training in these matters for staff, governors, and students.

Learning Opportunity 12

For Metropolitan Police. There are problems with the way that the silent solution is required to be operated by victims. Some consideration to changing the requirement for victims to press the number 5 twice could be given. The number five could be difficult to find, especially on a touch screen, and would light up the phone indicating it is being used, or that the victim has a phone.

Recommendations from the Review

Recommendations 1 – 5 have been made by Devon and Cornwall Police for themselves.

Recommendation 1

An understanding of stalking and harassment risk assessment interviews will be embedded into initial PCSO training. We further recommend that the implications of scoring should be fully understood and that training should be ongoing.

Recommendation 2

All incidents perceived to be stalking will be reviewed by a duty Inspector and control room Sergeant. The panel further recommends that supervising officers must have received training in domestic abuse and stalking, including safety planning and evidence gathering.

Recommendation 3

All frontline officers will be reminded that thorough research on victims and suspects must be undertaken to inform the DASH risk assessment grade before any submission is made. The panel further recommends that officers are in no doubt that the DASH

process cannot be a tick box exercise, and that certain characteristics are weighted more heavily than others.

Recommendation 4

A formal programme of refresher training will be introduced for all front line officers completing DASH risk assessments. The panel recommends that this should also include detective officers, supervising officers and control room staff.

Recommendation 5

Devon and Cornwall Police should embed domestic abuse risk assessment training and refresher training within a wider safeguarding training plan.

Recommendation 6

The panel recommends that Devon and Cornwall Police ensure that training goes beyond awareness, and covers safety planning, safety advice, and knowledge of existing safety options like the silent solution. This should include taking consideration of victim fear and perpetrator persistence. If this training is not resource effective there should be clearly identified officers on duty who can be consulted on this type of subject knowledge. Identified officers could be clearly identified in a high profile manner. We recommend domestic abuse and stalking specialists/champions throughout departments. Training and specialism should be represented in detective departments.

Any training package should be scrutinised to ensure that it will provide officers not only with awareness, but with skills to effectively carry out risk assessments and to be fully aware of all response options.

Recommendation 7

Where a history of stalking or domestic abuse is revealed officers should consider the option of disclosing this history to a victim at risk. There is a process for this. Victims could be supported to understand the risks posed by repeat abusers.

Recommendation 8

Public awareness of stalking and domestic abuse and the specific risks posed to victims, and dangerous behaviours in perpetrators is not high enough. Repeated public awareness campaigns through advertising or high profile posters, social media and TV, also to employers, could help people feel confident to disclose, and for perpetrator friends and family to challenge or report risky behaviours. Also public awareness around how to use the 999 system and the implications of the silent solution should be part of an immediate campaign.

Recommendation 9

This panel recommends that it is important that offenders are consistently challenged about their behaviours, and that meticulous evidence gathering should accompany all

potential prosecutions. Victims, who are described as unreliable or are unwilling and frightened to support prosecutions, should still be supported. A clear policy on prosecution should be available.

Recommendation 10

Homesafe teams should be sufficiently trained to recognize the importance of their visits to victims of domestic abuse and stalking. These should be prioritized. They should recognize that lock changes should always be carried out where a perpetrator has lived in the premises, or has ever, at any time, had access to a key.

Recommendation 11

The panel recommends that all schools are aware that many children will be suffering domestic abuse in their homes and that there should be safe spaces for children to disclose, and pastoral care from informed practitioners.

Recommendation 12

It is recommended that **the Metropolitan Police** consider updating their Silent Solution given that most phones are now touchscreen. There may be difficulties in attempting to find the number five on a touch screen phone, and the automatic lighting up of the screen if touched. These things make it very difficult in some circumstances to make a call in secret.