Safer Lincolnshire Partnership

Domestic Homicide Review – Executive Summary

The deaths of Louise and Grant

April 2017

Independent Author: Christine Graham

Preface

The Safer Lincolnshire Partnership wishes at the outset to express their deepest sympathy to the sons and extended family. This review has been undertaken in order that lessons can be learned from this situation and we appreciate the support and challenge of the families with this process.

The Independent Chair and Report Author would like to thank the staff from statutory and voluntary sector agencies who assisted in compiling this report.

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Section One – The Review Process

1.1 Introduction and agencies participating in the Review

This summary outlines the process undertaken by the Safer Lincolnshire Partnership Domestic Review Panel in reviewing the deaths of two of its residents. These deaths occurred in March 2017.

In order to protect the identity of the victim and her family members and the family of the perpetrator the following pseudonyms have been used:

Female victim: Louise who was 50 years old at the time of her death
Deceased Male: Grant who was 49 years old at the time of his death

When an ambulance was called, advised of a man hanging, it soon became clear that there were concerns for the whereabouts of the man's wife, Louise, who had not been seen for almost two weeks. The police classified Louise as a high risk missing person, the house and outbuildings were secured, and a specialist search team began a systematic search and Louise's body was discovered in a rarely used ground floor store room. Her body had been concealed under wallpaper, cloths and laminate flooring. The police began an investigation into the circumstances of both deaths. After a thorough investigation, there was no evidence to suggest that any third party was involved in the deaths of Louise and Grant. Whilst there is nothing to suggest that Grant's death was anything other than suicide, had he been alive, the police would have sought to question him about the circumstances of Louise's death.

The Coroner held an inquest into both deaths and recorded suicide in the case of Grant and an open verdict in the case of Louise as the pathology results did not allow the cause of her death to be ascertained.

Safer Lincolnshire Partnership was advised, in April 2017, by Lincolnshire Constabulary that the death of Louise and Grant had occurred. On 2nd May 2017 a partnership meeting was held and after due consideration of the circumstances that prevailed, a decision was made that a review would be held and that an independent chair would be appointed. On 4th May 2017 the Home Office was advised of this decision.

The Review Panel met for the first time on 17th July 2017. IMRs[1] were completed by those agencies who had been in contact with either Grant or Louise, as well as the Church of England and Louise's employer. The panel met on a number of occasions and the review's active enquiries concluded in February 2018. The report was completed in March 2018 and a final panel meeting was held on 24th April 2018.

The following agencies and individuals contributed to this review:

- Addaction
- BetelUK
- Boston Women's Aid
- Citizens' Advice Bureau
- College of West Anglia
- East Midlands Ambulance Service
- Employer of Louise
- GP for the family

[1] Independent Management Reviews

- Lincolnshire County Council, Children's Services
- Lincolnshire County Council, Safer Communities
- Lincolnshire Police
- Lincolnshire Probation
- Lincolnshire Partnership NHS Foundation Trust
- Queen Elizabeth Hospital
- The District Council
- South West Lincolnshire Clinical Commissioning Group
- United Lincolnshire Hospitals Trust
- West Lindsey District Council
- West Yorkshire Police
- Louise and Grant's sons
- Sister to Grant and cousin to Louise
- Close friends of Louise and Grant
- Local vicar
- Expert in cultural/domestic abuse issues

1.2 The Review Panel Members

The Panel was made up of the following members:

Gary Goose MBE	Independent Chair
Christine Graham	Overview Report Author
Natasha Swift	Addaction
Julie Lyon	Citizens' Advice Bureau
Paul O'Shea	College of West Anglia
Debbie Johnson	Diocese of Lincoln
Zoe Rodger-Fox	East Midlands Ambulance Service
	GP for family[2]
Head Teacher	School employer
Claire Tozer	South West Lincolnshire Clinical Commissioning Group
Roz Cordy	Lincolnshire County Council, Children's Services
John O'Connor	Lincolnshire County Council, Education
Liz Bainbridge	Lincolnshire Partnership NHS Foundation Trust
Ron Jackson	Lincolnshire Police
Sarah Norburn	Lincolnshire Police
Kim Plant	Probation CRC
Kay Crome	Queen Elizabeth Hospital, Kings Lynn
Emily Holmes	The District Council
Sarah Smith	South Lincolnshire Domestic Abuse Services
Emma Waters	West Lindsey District Council (domestic abuse expert to panel)
Allan Raw	West Yorkshire Police

1.3 Domestic Homicide Review Chair and Overview Report Author

1.3.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-

[2] The name of the GP has not been included to protect the anonymity of the family

profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary has been employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.3.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. Christine also delivers Partnership Health checks which provide an independent view of partnership arrangements. Christine is also a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews.

1.3.3 Gary, working alone, has completed six Domestic Homicide Reviews (as Chair and Report Author). Working together, Christine and Gary are involved with eleven reviews (one of which is complete).

1.3.4 Neither Gary Goose nor Christine Graham are or have been at any point in the past associated with any of the agencies involved in the review.[3]

1.3.5 Both Christine and Gary have:

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports
- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended the AAFDA Annual Conference (March 2017 and March 2018)
- Attended training on the statutory guidance update in 2016
- Undertaken Home Office approved training in April/May 2017

1.4 Purpose and Terms of Reference of the Review

According to the statutory guidance, the purpose of a DHR 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 on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36 page 12), Home Office, December 2016

approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity;

- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

The Panel agreed that the specific purpose of the Review is to:

- Establish the facts that led to the incident on 7th April 2017 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.

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

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on 7th April 2017; suggesting changes and/or identifying good practice where appropriate.

- 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.

The scope of the review, as agreed by the Panel, is to:

- Seek to establish whether the events of 7th April 2017 could have been reasonably predicted or prevented.

- Consider the period of from 1st January 2007 (when they moved to the area), subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

- 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.

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

- 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.

- 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.

Section Two –
Agency contact and information learnt from the Review

2.1 At different points over the years, the family came to the attention of the police and other agencies.

2.2 Grant, in particular, sought the support of a range of health services in relation to significant alcohol use. He was also subject to court interventions requiring him to address his alcohol issues.

2.3 Louise, on more than one occasion, sought help from Women's Aid.

2.4 Culture and faith played a significant part in the life of this family. There were a number of indicators and direct reports made to the police and other agencies about discord within the relationship.

Section Three -
Key issues arising from the Review

3.1 Cultural issues

3.1.2 Whilst we know that both Grant and Louise were from Christian heritage in Pakistan which makes up a small minority (approximately 2%) of the population, it has been important to the review to understand that culture and religion, for them both will have been very interlinked, and they would have been influenced very much by the culture of their home country, whilst practising as Christians.

3.1.3 In their Eastern culture, their experience of family life may have been very different from that which many of us in the West would recognise. This was seen when Grant and Louise met with the social worker. Grant clearly stated that in his culture a man is in charge and this is how he was brought up. He did not believe that he needed the help of Children's Services and, whilst Louise did not agree, for them, the needs of their family would have been a much greater than their own needs and maintaining the family unit would have been paramount.

3.1.4 There are important aspects of how the roles of men and women are defined within this culture. Women are seen as guardians of the family honour and there may have been expectations of obedience from her.[4] Research and the lived experience of our advisor; indicate that boys are not equally affected by these demands[5] which might suggest why Grant's behaviour was tolerated by the wider family.

3.1.5 It is important that we do not overlook the place that shame would have been likely to play in both of their lives. For Louise, we see evidence of her keeping the problems secret and this may well have been, at least in part, for a desire not to bring shame on her family, particularly given the position her father held as an archbishop in Pakistan. Her 'shaming' of the family might also have sparked further violence.[6] Grant also may have been very influenced by shame and we know that he was not happy when he knew that she had asked the church for help and this may have led to him feeling shamed. In their culture, they would have expected help to come from the family but, for Louise, the church was her family too.

3.1.6 If we consider why Louise did not disclose the violence we might do well to remember that within her culture, disclosure could increase the risk of violence, possibly even leading to long term rejection from the group (or family) due to the rigid rules of family honour.[7] In her eyes, the greatest good may not be removing the risk of violence at all costs but maintaining her place in the family whilst minimising the risks to her and the boys. South Asian culture is collectivist, prioritising group welfare over individual freedoms and we can see how this may have influenced her decisions about seeking help.

[4] Bano S, 2012, Muslim Women and Sari'ah Councils: Transcending the boundaries of Community and Law, Basingstoke, Palgrave Macmillan

[5] Dion K K and Dion K L, 2001, Gender and Cultural Adaptation in Immigrant Families, Journal of Social Issues, 57 (3), 511-521

[6] Bano S, 2012, Muslim Women and Sari'ah Councils: Transcending the boundaries of Community and Law, Basingstoke, Palgrave Macmillan

[7] Lago 6, 2008, Race, Culture and Counselling: The Ongoing Challenge (2nd edition), Milton Keynes, OUP

3.2 Alcohol

3.2.1 It is important that we acknowledge that whilst Grant and Louise had a complex relationship, by the nature of this review, we have focused upon the times when it was at its worst The boys would talk about some very happy times as a family which could extend to months at a time except when their dad was drinking. It appears that, at least until the more recent years, Grant could go for some weeks or months without drinking and then he would begin to drink socially, and it would spiral out of control. Christmas was described as one such trigger.

3.2.2 However, over the years Grant's drinking became more and more of an issue causing him to lose a number of jobs. Friends and family described Grant as being desperate to give up drinking but, unfortunately, his interactions with treatment services do not support this view.

3.2.3 As so many people we spoke to about Grant attributed the problems in his marriage and life to his problems with alcohol, it is important that we face head on the role that alcohol may or may not play in domestic abuse.

3.2.4 Research finds that between 25% and 50% of those who perpetrate domestic abuse have been drinking at the time of the assault[8] and cases involving severe violence are twice as likely to include alcohol[9]. It has also been found that in an intimate relationship where one partner has a problem with alcohol or other drugs, domestic abuse is more likely to occur[10]. However, the impact of alcohol on domestic abuse is complicated.

3.2.5 It is important that we remember that domestic abuse is about power and control by one partner over the other. Not all alcoholics are abusive and not everyone who abuses their partner is alcoholic. Whilst we can say that alcohol is a compounding factor in a person being abusive towards their partner we must avoid suggesting that it *causes* it. Alcohol is *not* the cause of the abuse or the violence, the desire for power and control is. Alcohol may be offered as a reason, or an excuse, for the abuse but this should not be accepted and the responsibility for his actions should not be removed from the perpetrator by blaming the fact that he had been drinking.

3.2.6 Alcohol was a factor in this case but Grant's character is at the root of the issues within this relationship, alcohol compounded them.

3.3 Evidence of domestic abuse

3.3.1 Domestic abuse takes many forms and what we see in Grant is a man who was controlling and manipulative in many situations. We have no doubt that this was true of his behaviour towards Louise, but as she went to great lengths to keep this from even her closest friends,

[8] Bennett L and Bland P, Substance Abuse and Intimate Partner Violence, National online recourse centre on violence against women, cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

[9] McKinney C et al (2008), Alcohol Availability and Intimate Partner Violence Among US Couples, cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

[10] Galvani S, (May 2010), Supporting families affected by substance misuse and domestic violence, The Tilda Goldberg Centre for Social Work and Social Care, University of Bedfordshire, ADFAM, p5 cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

we cannot know the extent to which this went on. Examples are contained within section 3 of the main report.

3.3.2 Although we cannot know the full extent of his control and manipulation of Louise, what we can see are examples of his controlling and manipulative personality in other situations and relationships.

3.3.3 Grant's friends described him as being manipulative, 'he was always two steps ahead of you'. He manipulated friendships and the image of himself that he liked to portray. He was known for being 'flash' in the pub and making a big show of buying drinks for everyone. He, on one occasion, put a £20 note in the church collection so that everyone could see. This might, as was suggested the person who told us about it, have been an example of his generosity or, alternatively, it might have another example of him manipulating people's impression of him.

3.3.4 Grant was obviously able to tell a good story and was very plausible. He was able, on more than one occasion, to persuade car dealerships to lend him top of the range cars to try out 'as he might be thinking of moving his company's fleet to them'.

3.3.5 We see, in Grant, a man who would always seek to ensure that things happened on his terms. He was referred by LPFT for a stress management course but only attended two of the five sessions. When he attended BetelUK and AA, he stayed for as long as he wanted and took from the intervention what he wanted. When he was before the courts, on one occasion he was required to undertake unpaid work which he clearly did not want to do. After turning up drunk one day this was deemed unsuitable and, when taken back to court it was replaced with a curfew. On another occasion, he obtained sick notes from his doctor so that he did not have to engage in a work party.

3.3.6 We cannot know the extent to which Louise was a victim of financial abuse but what we do know is that for many years she shouldered the burden of their finances, seemingly alone. Their finances were a constant worry for Louise, although she kept this from her sons. She was the sole earner in the family, working full time whilst looking after the family. They lived in a large house and were, on and off for many years, in danger of the house being repossessed. She had, on numerous occasions, asked friends, colleagues and even her employer, to lend her money or give her food.

3.3.7 We also know that Louise saw a solution to their problems would be to declare themselves bankrupt, sell their house, rent a smaller house and start again. Despite all that they had been through, she wanted this new start to be for them all. She had talked with her vicar, before returning home prior to her death, about this plan and had arranged with him for the church to give them the money for the deposit on a rented property. We know, from previous times when this had been considered, that Grant would not agree, seeing the shame of losing his big house and declaring himself bankrupt as worse than their current situation.

3.4 Why did Louise tell some of her story but not all of it?

3.4.1 This review was told by a number of people that Louise, as we were told by a number of people, loved Grant very much. We know that, over the years, there were times when one or the other of them would move out of the house, but they always reunited. Louise was a private woman who wanted to protect Grant.

3.4.2 We have had had lots of evidence from friends and colleagues that Louise shared some very personal information with them, but she did not tell them everything.

3.4.3 There is no doubt that her cultural and religious background would have played an enormous part in her thinking and her actions. She had married Grant, against the advice of her family, in the eyes of God and she had married for life. We have heard the strength of her faith in every area of her life and she was known, on more than one occasion, to ask friends to pray for her and her family.

3.4.4 Louise also would not wish to bring shame on her family or on Grant by speaking about his problems. It may be difficult for those from a western culture to understand why this was so difficult for her.

3.4.5 Whilst this review has referred to her religious and cultural beliefs, we acknowledge that there may have been other reasons why Louise did not tell anyone about her situation. Although we see, in the picture that has been painted for us of Louise, a cheerful and competent woman there is no doubt that she was controlled by Grant and, most probably, afraid of him and what he was capable of.

3.4.6 The review panel has spent some time considering the position that Louise was in as a professional woman who would be dealing with safeguarding issues on a day to day basis. She knew that if she disclosed the violence and abuse that she was experiencing that there would be consequences. Agencies would have become more involved and this could have had a life changing impact upon her, her children and her career. This may lead women in such a position to minimise to themselves and others the abuse that they are experiencing and not to seek help. She was, in her work, supporting children who had been affected by domestic abuse and therefore she would know the impact that this could be having on her own children. This has raised questions for the panel about how organisations with safeguarding responsibilities encourage staff who are suffering from abuse to seek help from their employers.

Section Four - Conclusions

4.1 The review concludes that Louise and Grant's marriage, whilst at times, happy, was over a period of years, subject to controlling, manipulative and violent behaviour by Grant towards Louise. Grant's alcohol misuse played a significant part in their marriage and it is clear that, despite numerous offers of help, he did not engage proactively with any of these but rather, dabbled, on his terms. This is not to excuse his abusive behaviour but to point out that this was how he approached all aspects of his life – it was on his terms.

4.2 We will never know exactly what happened that last weekend, but we believe that, for Louise, things were different because never before had Grant had an affair and she told her son that she could not forgive him for this. Both boys believe that, this time, she was really going to leave him for good. However, we know that when she visited the vicar the next day she said that, despite the affair, they were going to stay together.

4.3 Despite the involvement over the years with this family, the review is not able to say that the death could have been prevented. All agencies acted appropriately, with the policies they have, in the engagement that they had with both Louise and Grant. Whether a different DASH model would have meant that she was graded at a higher risk and therefore the situation may have been different is beyond the scope of this review but is reflected in the recommendations.

4.4 The review is satisfied that, at the present time, Lincolnshire is making great efforts to provide support for victims of domestic abuse through a range of different avenues.

4.5 Our thoughts are with the surviving friends and families, especially the two children.

Section Five – Recommendations

Children's Safeguarding Board

(1) That the business case for implementation of Operation Encompass is seriously considered and the scheme is adopted as soon as possible

Safer Lincolnshire Partnership

(2) It is recommended the Safer Lincolnshire Partnership considers actively encouraging organisations to engage with the available initiatives with a view to improving the support to employees who are victims of domestic abuse

Queen Elizabeth Hospital NHS Foundation Trust, King's Lynn

(3) That the Gynaecology Outpatient Clinic and Breast Care Service at Queen Elizabeth Hospital each identify a practitioner to complete the domestic violence champions training (delivered locally by Norfolk County Community Safety Partnership) and to attend the safeguarding champions' group.

(4) That the Queen Elizabeth Hospital audits whether staff are routinely asking the question about domestic violence and abuse

(5) That the QEH Trust Domestic Abuse Policy is updated to include NICE guidance recommendations

(6) That the safeguarding children and adult team at QEH review the current provision of training around domestic violence and abuse against the NICE Quality Standards 2014

Lincolnshire County Council

(7) That Lincolnshire County Council reviews its absence policy with a view to providing more guidance on the action that should be taken if a member of staff does not comply with the policy and make contact personally. This review should consider how the school and unions can work together to ensure that staff understand the need for the safe and well check

South Holland District Council

(8) That the case management system and process is reviewed to avoid duplicate records and build in a check of details of other names known by

(9) That the notes are maximised to:

- Capture the detail of the contact;
- Record of the risk assessment;
- Capture and record supervision action in case notes;

(10) That there is effective liaison with other service providers – for example, the risk of domestic abuse that is recorded in housing files was not shared with revenue and benefits Department at the time.

GP surgery for Grant and Louise

(11) That the surgery introduces a policy for adult safeguarding especially domestic abuse

(12) That GPs record in detail any conversations that they have with patients with depression and demonstrate on the record how they have looked at the possibilities of the underlying reason

Diocese of Lincoln

(13) That the statutory agencies work closely with the church to harness the willingness to establish better local relationships and to contribute to a better understanding by agencies of the role of faith communities in the lives of their members. It is recommended that the work begun to have a conversation about the church's teaching on being a 'good neighbour' continues

LSCB/LSAB

(14) That the safeguarding boards in Lincolnshire ensure they are engaged with the faith community in their safeguarding processes so that churches can be included in the planning and assessment of families and individuals, recognising that, where people are very involved in their faith life, the church can provide a significant source of support and comfort and that Clergy and church officers could have active roles in addressing the support needs of their members

Diocese of Lincoln

(15) That the Diocesan Safeguarding Team completes its Parish Audits during 2018 to enable targeted support to be offered to Parishes who are struggling to mainstream good safeguarding practice within the ministry and mission of the local Church

(16) That the Domestic Abuse module of the Church of England Safeguarding Training is delivered during the second half of 2018