Safer Lincolnshire Partnership

Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Sam
in June 2018

Report Author: Christine Graham
May 2020

Preface

Safer Lincolnshire Partnership wishes at the outset to express their deepest sympathy to Sam's family and friends. This review has been undertaken in order that lessons can learned; we appreciate their support, and challenge throughout the process.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by Safer Lincolnshire Partnership on receiving notification of the death of Sam in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Sam was a much loved son, husband and daddy. He was a gentle, placid, happy go lucky man who would do anything for anyone. He was once described as a big soft teddy bear and that's just what he was. He loved his family especially his children, he loved to watch TV, go for a pint, playing pool and watching speedway.

Unfortunately, this changed when he met someone, he became withdrawn and not the person we all knew and loved.

Losing Sam in such a cruel and senseless way has had a devastating effect on all our lives, especially his parents as he was their last surviving son.

Sam will always be remembered and missed so much by all of us.

Sam was the first-born child and, as such, was special and cherished. You look to raise him correctly, sometimes strict with consequences that you later regret. The following siblings are allowed to get away (behaviour wise) with all and everything.

Then one dies, very young, seen nothing of the world or even made a mark. You are told by your elders not to grieve or be too hard on yourselves, time will heal, you are young, other children will come along. To a point they were correct, a further son is born, the first born and his brother become close, and he looks out for him. Teenage years come and both boys go racing, life goes forward. The first born marries has children, his brother becomes a godparent, a very close relationship is established (more than the parent is aware).

Then the unforeseen occurs, - the death of the younger one, the parent is left with one son, the first born. Too old this time to recreate, but a son, good, bad or indifferent, but a son to have a beer with to talk speedway, and hopefully look after the old man in his later years, to laugh, cry, and say you know where I am if you need anything.

Then the final call, your son is in ICU, critical. Nothing prepares you for the moment as you watch your first born take his last breath as the life support equipment ceases to uphold his life. Old as he is he is still the first-born.

How has this affected me - devastated, sad, lost. After all he was the first born.

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1.1 The Review Process

1.1.1 This summary outlines the review process undertaken by the Safer Lincolnshire Partnership Domestic Homicide Review Panel in reviewing the homicide of 'Sam' who was a resident in their area. Sam died as a result of homicide, which occurred in June 2018.

1.1.2 The following pseudonyms have been used in this review for the victim and perpetrator in order to protect their identities and those of their family members:

'Sam' for the victim. Sam was a 46 year old white british man at the time of his death. He was a father of three children and was separated from his wife with whom he had three children.

'Beverley' for the perpetrator. Beverley was a 43 year old white british woman at the time of the homicide. She had separated from her husband with whom she had two children.

Sam and Beverley had separated from their respective spouses to form a relationship together. They had been in that relationship for around 5 years at the time of the homicide.

1.1.3 Sam's death arose as a result of fatal injuries he received after being thrown from the bonnet of Beverley's car. The couple had spent an afternoon in a local public house where an argument began between them. That argument continued into the car park and Beverley drove off with Sam on the bonnet of the car.

1.1.4 Following Sam's death, criminal proceedings were initiated against Beverley. She pleaded not guilty but after a trial, in March 2019, she was convicted of his manslaughter. She received a sentence of 10 years' imprisonment together with a ban from driving which will come into force upon her subsequent release from custody.

1.1.5 The Safer Lincolnshire Partnership were immediately informed of the homicide and the Chair of the Strategic Board considered the case, in conjunction with other key agencies that had contact with the family, and concluded that the case met the criteria for a Domestic Homicide Review. The Home Office were notified 12th July 2018. At this point, as a result of the sensitivity of the criminal proceedings, the review was pended, awaiting the criminal trial. An independent Chair and Author were appointed in January 2019 and the family were told about the intention to hold a review on 21st January 2019.

1.1.6 A total of eight agencies confirmed prior contact with the couple or other relevant parties and were asked to secure their files for the purposes of this review.

1.2 Contributors to the Review

1.2.1 Individual Management Reports, or summary reports, were provided by:

- Cambridgeshire Constabulary
- East Midlands Ambulance Service NHS Trust
- GP practice
- Lincolnshire Community Health Services NHS Trust

- Lincolnshire County Council – Children's Services
- Lincolnshire Police
- Peterborough City Hospital
- United Lincolnshire Hospitals NHS Trust

1.2.2 The Report Author had met members of Sam's family whilst attending the trial. Once the trial was complete, the Chair and Report Author met with a number of Sam's family members, some of whom were supported by an AAFDA advocate. The Report Author also met with the landlord and landlady of the public house.

1.2.3 The Chair and report Author were independent of any of the agencies involved in this case by virtue of not being employed by any of the agencies and living/working in another county area not served by the commissioning area for this review.

1.3 Review Panel

1.3.1 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Jane Keenlyside	Senior Project Worker	End Domestic Abuse Now Lincs[1]
	Business Manager	GP surgery[2]
Sarah Reed	Senior Probation Officer (Offender Management)	HMP & Probation Services
Ali Balderstone	Deputy Named Nurse for Safeguarding	Lincolnshire Community Health Service
Jade Sullivan	Domestic Abuse Lead	Lincolnshire County Council
Natalie Watkinson	Domestic Abuse Project Officer	Lincolnshire County Council
Teresa Tennant	DHR Administration	Lincolnshire County Council
Yvonne Shearwood	Head of Service Regulated (South)	Lincolnshire County Council – Children's Services
Claire Saggiorato	Children's Safeguarding Lead Nurse	Lincolnshire County Council Children's Health
Detective Superintendent Jon McAdam	Head of Protecting Vulnerable Persons Unit	Lincolnshire Police
Dee Bedford	Community Safety and Enforcement Manager	South Holland District Council
Claire Tozer	Safeguarding Adults and Children Lead	South West Lincolnshire Clinical Commissioning Group
Elaine Todd	Named Nurse for Safeguarding Children and Young People	United Lincolnshire Hospitals NHS Trust

[1] This agency supports both female and male victims/survivors of domestic abuse
[2] Name not included to protect the anonymity of the victim

1.3.2 **Advisers to the Panel**

Toni Geraghty	Assistant Chief Legal Officer	Legal Services Lincolnshire

1.3.3 None of the panel members had direct involvement with the case and were thus independent for the purposes of this review.

1.4 Domestic Homicide Review Chair and Overview Report Author

1.4.1 Gary Goose was the independent chair for this review. He was formally a police officer rising to the rank of Detective Chief Inspector: his policing career concluded in 2011. During this time, as well as leading high- 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 was employed by a Unitary Authority 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. Since 2016 Gary has completed a number of domestic homicide and other safeguarding reviews in his capacity as overview author and Chair. Training and other qualifications are set out below.

1.4.2 Christine Graham was the independent author for this review. She formally 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 spent seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. She now chairs the Safer off the Streets Partnership in Peterborough.

1.4.3 Gary and Christine have completed, or are currently engaged upon, a significant number of Domestic Homicide Reviews. Have engaged with numerous bereaved families, victims of domestic abuse, perpetrators and perpetrators families. Previous Domestic Homicide Reviews have included a variety of different scenarios: male victims; suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim; and, reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the IOPC, NHS England and Adult Care Reviews.

1.4.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review.[3]

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

1.4.5 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)
- Attended training on the statutory guidance update (2016)
- Undertaken Home Office approved training (April/May 2017)
- Attended the AAFDA Annual Conference (March 2018)
- Attended Conference on Coercion and Control (Bristol, June 2018)
- Attended AAFDA Learning Event (Bradford, September 2018)
- Attended AAFDA Annual Conference (March 2019)
- Attended AAFDA Information and Networking Event (November 2019) - Christine

1.5 Summary Chronology

1.5.1 Sam and his wife, and Beverley and her husband, were two couple who were friends. During 2013, a relationship formed between Sam and Beverley that led to them separating from their respective spouses. They then began to live together.

1.5.2 Prior to their relationship, Sam had suffered from a serious illness. The result of the subsequent surgery had left him with low self-esteem and in the view of his family, vulnerable to manipulation.

1.5.3 Beverley was well known to local healthcare services, in particular primary care, as she regularly complained of a variety of ailments: few were diagnosed.

1.5.4 The couples relationship was prone to argument and over the course of the next few years, police and other agencies became aware of their relationship.

1.5.5 Within the first year, police and other services were called three times to them. These calls ranged from incidents reportedly involving an ex-partner, to concerns about Beverley's whereabouts, and to Sam harming himself as a result of an argument between them. Sam also attended the Minor Injuries Unit with a burn to his arm. At the time, he said he had injured himself in an accident with a iron. It has since come to light that he told his family that Beverley had in fact caused the injury with an iron during an argument. Sam was also reporting depression to his GP. Beverley also attended A&E as a result of what she said was a fall down the stairs.

1.5.6 Following the incident with the iron, the couple separated for a few weeks; Sam returned to live with his father. His family implored him not to return to her but he did, saying to his father "who else would want me?" (referring to the results of his illness). Whilst we are unable to say that the iron incident caused the separation on its own, they certainly separated around this time and it is reasonable to conclude that it was at least one of the factors in that separation.

1.5.6 This pattern of engagement with agencies continued during the following years. In 2014, Sam took an overdose requiring hospitalisation. He was later arrested as a result of a separate incident following a report of an argument at their home. Beverley alleged that he had assaulted her. He was subsequently cautioned for Common Assault. At the time, she said she was afraid of him when he drank because he became violent.

1.5.7 Beverley reported a number of collapses at home and attended her GP complaining of ear pain as a result of Sam's attack upon her. She was subsequently declared fit for work.

1.5.8 The couple were suffering from financial difficulties, to the extent that Sam was asking his father to pay for diesel for his vehicle. Sam worked, but it was seasonal work driving for a local agricultural firm.

1.5.9 Sam's family began to be concerned about Beverley's level of control over him. They say that as time progressed she dictated what shifts he could work and began to contact his employer directly saying when he was and when he was not available. They say she also wanted to know where he was all the time and then when he visited them, he always had to get back to her.

1.5.10 In 2016, Beverley took an overdose resulting in her attendance at hospital. She said this was as a result of believing her partner (Sam) was in contact with another woman.

1.5.11 In 2017, due to their financial woes, the couple moved to a static caravan on unplanned land. By the end of the year, the local authority had written to the owner of the land telling them that they must vacate the caravan with 'reasonable notice'.

1.5.12 In early 2018, they were provided with temporary accommodation by the local authority as they were homeless. They got into rent arears quickly, in relation to this, and were in conversations with the local authority about this from around April until the time of Sam's death in June.

1.6 Key issues and lessons identified arising from this review.

1.6.1 This is a case where we know that Beverley was responsible for Sam's death. We also know that she claimed in her trial that she had been a victim of violence at the hands of Sam. The role of this review is to seek to identify if there is a trail of domestic abuse in this relationship. There is some evidence to suggest that Sam was violent towards Beverley. There is also information from Sam's family and friends that Beverley was manipulative and controlling of Sam. Ultimately, there are only two people who know the truth about the relationship, but we have sought to explore the evidence available to the review.

1.6.2 That this relationship was difficult is clear from the information gathered by the criminal investigation and this review. Sam told his family that he regretted getting involved with her but it is likely that his low self-esteem and the male view of 'weakness' if reporting domestic abuse, ultimately meant he put up with her behaviour and would not leave the relationship. Support for male victims is thus a key feature of this review.

1.6.3 There was significant involvement by a range of agencies with both Sam and Beverley as individuals and as a couple. Whilst there is some evidence of agencies signposting for support, there is a lack of a co-ordinated approach to support. The couple's living arrangements must have impacted upon their aleady difficult relationship and, whilst all agencies addressed what they believed to be the couple's needs, this was done at individual agency basis rather than in a co-ordinated way.

1.6.4 This review, however, is aware of Lincolnshire's ongoing approach to domestic abuse and the issue raised above is something that is being constantly addressed and improved.

1.7 Conclusions

1.7.1 This review has learnt that, from the evidence of family and friends, they believe this perpetrator was controlling of Sam within the relationship. The extent to which there was violence and control between both parties we cannot be certain. Sam was known to be violent towards Beverley on one occasion. We do know, from the remarks of the Judge in sentencing, that Beverley had no regard for Sam, the man she claimed to love, on the day of the incident and was, at least disrespectful to him when he was laying in the road. We know that she continued to exacerbate the situation by causing messages to be posted on Facebook blaming others for Sam's death.

1.7.2 Those who were present when the argument occurred in the pub said that what happened was not in the heat of the moment but was 'a control thing with her'.

1.7.3 On balance, with the caveats set out earlier, the review feels that there is information that Beverley behaved towards Sam, both on the day of the incident and throughout their relationship, in a way that was manipulating, controlling and coercive.

1.7.4 This review has learned of good examples of work in some local agencies that has showed professional curiosity in relation to domestic abuse. However, there is more to be done, particularly in relation to the messaging around male victims of abuse, and professional curiosity across all those agencies charged with the responsibility for safeguarding the vulnerable. We believe the recommendations in Section Six will make others safer.

1.8 Recommendations

The review is grateful to the organisations for their thorough IMRs and the recommendations that they have made for their organisations. These are listed below:

East Midlands Ambulance Service NHS Trust

1.8.1 That all crew are reminded about the importance of recording the details of all conversations held with patients.

United Lincolnshire Hospitals NHS Trust

1.8.2 That the Named Nurse for Safeguarding commissions an audit of assault-related attendances, in each of the A&E departments, in order to assess compliance with the Trust and local Domestic Abuse processes.

In addition, the review has made the following recommendation:

Safer Lincolnshire Partnership

1.8.3 That all public-facing agencies in the partnership review their training for staff and volunteers to ensure that appropriate responses are given to men when reporting domestic abuse.