

Safer Peterborough Partnership



An overview report concerning the Domestic Homicide of EC

Revised overview report (Highlighted represent the **original** text, all of the rest of the report is the **NEW** updated version)

This version is the subject of re-submission to the Home Office and is to be regarded as the overarching document.

1.0 Introduction:

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 those lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims, their children and/or other relatives through improved intra and inter-agency working.

1.1 The Safer Peterborough Partnership (SPP) is committed to a clear approach to dealing with domestic abuse within strong statutory and non-statutory partnerships. The SPP has created a strategic vision from 2012 extending into 2015, when the partnership will be in a strong position to examine what has been achieved and where gaps in practice exist in order to drive forward future strategies.

1.2 That vision is stated as being:

To develop a sustainable approach to addressing domestic abuse within Peterborough by:

- Preventing abuse from occurring by raising awareness, delivering education and challenging attitudes amongst both young people and adults.
- Intervening early to prevent escalation and reduce risk.
- Providing support for victims to enable them to recover and move on from abuse.
- Protecting children from harm who live within an environment where there is domestic abuse.
- Bringing perpetrators to justice and provide interventions to change their behaviour and prevent future victims.
- Working in partnership to make best use of resources and knowledge.
- Providing robust governance and scrutiny of all work to address domestic abuse in the city.

1.3 Peterborough has a particularly diverse community, and although there is some conjecture as to the actual number of languages spoken, it is suggested that between 80 and 100 nationalities are represented within the community. The challenges that such diversity brings have been recognised by a range of partnerships working together and designed to safeguard the public.

1.4 Changes in legislation for example the inclusion of coercive and controlling behaviour announced recently by the Home Secretary, will be fully integrated into the SPP Strategic vision.

1.5 This Domestic Homicide Review (DHR) examines the circumstances surrounding the tragic death of a 64 year old white British woman herein referenced as the victim. The victim had been married

to her husband the perpetrator, since 1981, and they had been married for some 31 years at the time of her tragic death which occurred on May 24th 2012.

1.6 On 7 June 2012, Cambridgeshire Constabulary notified the Chair of the Community Safety Partnership (known as the Safer Peterborough Partnership (SPP)) that a murder was under investigation that appeared to be a domestic homicide. This was in accordance with national practice guidance.

1.7 After further consultation and advice, the Chair of the CSP determined that a Domestic Homicide Review was not required and informed the Home Office of her decision on 30th August 2012. The reason for this decision was that:

- There was no history of domestic violence within the household
- No apparent pre-cursor incidents had occurred that the police or other partnership agencies had been aware of.

1.8 On 27 November 2012, a representative from the Home Office asked the Chair of the Community Safety Partnership to review her decision and to commission a proportionate review. The CSP Chair subsequently agreed to do so.

1.9 An independent panel chair and overview report writer, Felicity Schofield, was commissioned in December 2013. She is an experienced author of domestic homicide and serious case reviews. She is a social worker by profession and has never practiced in Peterborough.

1.10 This amended version of the report has been prepared by Mr Russell Wate QPM, a retired senior police detective, who is the former Independent Chair of the Hammersmith and Fulham LSCB and is the current Independent Chair for both the Peterborough LSCB and Safeguarding Adults Boards. Mr Wate has extensive experience of leading homicide investigations, including child deaths and domestic homicides and is also an independent overview author, who has also written a number of DHR's.

1.11 The following organisations were approached for information:

- Cambridgeshire Constabulary
- Cambridgeshire & Peterborough NHS Foundation Trust
- General Practitioner
- Peterborough & Fenland MIND
- Peterborough City Council; Domestic Abuse Service
- Peterborough City Council; Adult Social Care
- Peterborough Prison (Sodexo Justice Services)
- Peterborough & Stamford Hospitals NHS Foundation Trust
- Peterborough Women's Aid
- Relate Peterborough
- Cambridgeshire & Peterborough Probation Trust

The Information that was received back from the above agencies were in effect their IMR's for the purpose of informing the agencies themselves of any learning, and at the same time for the purpose of this overview report.

1.12 The process was overseen by a panel of senior managers from the Community Safety Partnership including the police, the city council, an independent housing provider and the health clinical commissioning group. This new and updated overview report has been shared with Women's Aid from the voluntary sector to ensure that the views of both the voluntary sector and the current specialist providers of domestic abuse services were appropriately consulted.

1.13 The victim's brother and sister-in-law have been consulted extensively as part of this review and were supportive of the purpose and process. It should be noted that they have made significant efforts to assist the review in gaining a deeper insight into the lives of victim and the perpetrator, but were they themselves only able to provide a limited perspective of the couple due to their relatively limited contact with them. The review tried to establish why there was limited contact, but it appears this was just the pattern of how they lived their lives.

2.0 The facts in this case.

2.1 The victim and perpetrator were married in 1981. They met in Yorkshire, where they were both living at the time. Neither had been married before. The victim was five years older than her husband. There were no children from the marriage.

2.2 The couple moved to Peterborough in 1989. Both worked throughout their adult lives in a variety of jobs, although following redundancy in the mid-1990's the victim had taken early retirement and does not appear to have worked since that time.

2.3 In 1998 the victim was diagnosed with cancer from which she made a good recovery following treatment. The carer was her husband the perpetrator throughout her illness, with occasional contact and support from both their respective families.

2.4 They lived together in a mid-sized terraced home which they owned¹ in a predominantly residential street within the city. The couple had moved to the Peterborough area from West Yorkshire in the late 1980's for the purpose of employment re-location by the perpetrator. Although he was later made redundant in early 2000, he found alternative employment at a local family run business and he remained working for them at the time of the tragic events. The victim did not work, although she had previously been employed but following redundancy in the mid 1990's, she appears not to have worked but had a small pension income from her earlier employment.

2.5 The circumstances surrounding the victim's tragic death are that on 24th May 2012, police officers attended the home of the couple having been alerted by the husband's employer, following his failure to attend for work. The perpetrator had told his manager by telephone that he thought that he had killed his wife. On arrival, officers discovered the body of the victim, whom they were sadly unable to revive. The perpetrator informed the officers that he was responsible for his wife's death and he was arrested for her murder.

2.6 The cause of death was asphyxia by strangulation, no weapons were used. There was no other evidence of recent or historical injuries sustained by the victim. A medical examination of the

¹ This property was mortgaged and although owned by them was purchased with an 'interest only' mortgage, which was a feature of the background by the police investigation.

perpetrator revealed some apparent minor injuries to him that were consistent with defensive efforts made by the victim.

2.7 The perpetrator was convicted of his wife's murder in September 2013 and he was given a life sentence. He had pleaded not guilty to murder on the grounds of diminished responsibility. An initial trial resulted in a hung jury and the September re-trial delivered a majority verdict of murder. Other than the significant statement made to the arresting police officers at the time, the perpetrator has never spoken about the events which led to his wife's murder by him. He made no comment in the extensive police interviews conducted following his arrest. Consideration was made to interview him in presence to assist the review, but due to his lack of comment and his still apparent not accepting his full guilt, it was deemed not appropriate at this time.

2.8 The perpetrator had worked in the printing industry since leaving school and had been employed by the same small printing firm since 2000. He was described by colleagues as being a good worker, always punctual and reliable, although quiet and a little set in his ways. He would never lose his temper or show any sign of aggression, but could panic and get worried over quite small things as commented by several of his former work colleagues. There is no evidence to indicate that he was diagnosed with any health or mental health condition, but he appeared to have a slightly nervous disposition. The police investigation made contact with neighbours and work colleagues in order to establish more 'independent' information about the couple, but with limited success. Likewise, they were unable to assist this review with any risk factors that may have existed in this case.

2.9 The couple had no obvious friends and appear to have led a routine and quite insular life. Few of the work colleagues knew, or had met the victim, other than at the annual work Christmas party. Although they liked to go to the same public house for a meal every Sunday and had some occasional contact with the victim's brother and his family who lived in the adjacent County. Other than that they seemed to live quite an independent and private lifestyle with little social outlook. Quotes made by a number of both family and colleagues of the perpetrator, during the police background enquiries centred on the understanding that they both appeared to "keep themselves to themselves". The perpetrator for example did not appear to talk about his wife or his home life whilst at work or socialise with his work colleagues outside of the work environment.

2.10 The perpetrator enjoyed old movies and was a keen collector of vinyl records. In respect of the victim's interests and hobbies, little is known. The victim appears to have remained at home whilst the perpetrator was at work and it is not clear if this was by desire or by influence on her from him. Whether or not the perpetrator influenced coercive control over the victim is not clear. However, it would be a fair analysis to suggest that the representation of their lifestyle is predicated by the perpetrators control as opposed to any obvious influence or desire from the victim.

2.11 In the months before the victims tragic death, the work at the perpetrator's workplace began to decline, with two members of the company's staff being made redundant and the remaining staff, including him, being put on a 4 day week. In essence this had a net effect of reducing his salary by some 20%, a not insignificant amount considering that his salary was reported to have been just some £12,000 per annum.

2.12 In 2007, the couple had re-mortgaged their house, borrowing £75,000 over a period of 10 years, again on an interest only basis with the capital sum needing to be repaid in 2017. They had paid off the original loan amount, some £40,000, which had been borrowed in 1989 when they had originally settled in the city. It appears that they had no obvious savings or arrangements in order to secure the settlement of that capital sum. It is not clear how this would affect their future plans, but the combination of the concerns in reduction of hours for the perpetrator and the possibility of redundancy coupled with the fact that in order to realise the capital sum, they would have to sell their home, may have had a profound effect on their financial outlook. Without support and sound advice, this would have had a significant impact on them.

2.13 In April 2012, they had contacted a mortgage consultant, explaining that they were worried about their mortgage because of the fact that the perpetrator was now on a four day working week. A meeting was arranged for August 2012 for them with an advisor when their fixed interest rate was due to change. In fact the mortgage rate that they were paying was much higher than was currently possible, having been set at the time of higher rates in 2007. The mortgage capital sum was due to be re-paid in 2017.

2.14 Work colleagues confirmed that the perpetrator was very worried about his financial situation and that he had become even quieter than usual. In fact his colleagues tried to help, with his employer making an appointment for him with the Citizen's Advice Bureau, which he subsequently cancelled. It appears that the victim was aware of this appointment, having been notified of this by the perpetrators employer in a telephone call to her.

2.15 The couple's family were also aware of their financial worries although they were not aware of the full extent or that they had in fact re-mortgaged their house for a larger capital sum than originally undertaken. The family, in particular the victim's brother, had informed them that he was willing to help with offers of financial guidance, support and advice.

2.16 On 23rd May 2012, the day before the victim's tragic death, the perpetrator finished work at his usual time. There was no concern raised about his demeanour or behaviour at work that day. However the following morning he did not turn up for work, which was very unusual and out of character for him. Consequently his employer rang him at home and the perpetrator immediately told him that he thought that he had killed his wife the victim.

2.17 The employer, fearing the worst made an emergency call to the police with officers attending the home within minutes of the telephone conversation between the perpetrator and his employer. On their arrival at the house, he openly informed the officers that he had killed his wife. There were no signs of any disturbance, the house was tidy and there was evidence of someone having had breakfast. There was no evidence that alcohol, drugs or any other intoxicants contributed to the death of the victim.

2.18 Due to the nature of the investigation, the police took the step of making a mental health assessment of the perpetrator, in order to ensure that the investigation was able to proceed. When interviewed later that day by a psychiatrist, he responded by stating "everything had got on top of him, mortgage, money and everything". He also stated that he was worried his wife would find out that he was a "pervert" because a week ago she had found out about him 'flashing' and also knew

that he watched pornographic films². However, the comprehensive police investigation discovered no reports of a 'flasher' that in any way met his physical description or appearance. There were no pornographic films or media found at the address, although a later viewing of the seized material identified one film of what the police described as a 'mainstream' release that would not ordinarily be described as being pornographic.

2.19 When the perpetrator was formally questioned by the police, he declined to answer any questions about the circumstances of death of his wife and this stance continued throughout his time in custody, despite extensive interviews. He gave no impression to the interviewing officers that he either wanted to or was willing to talk about the events.

2.20 All relevant local statutory agencies were contacted as part of the police investigation and also as part of this DHR process, in order to establish whether any information existed that might have suggested domestic abuse present within the household or any indication of violence by the perpetrator or victim. Unusually for a case of this nature, there was no information held by any organisation which might have identified any overt risk presented against the victim by the perpetrator. The police senior investigating officer commented that the case was unique in respect of how little was known, despite their efforts to uncover pre-cursor information, intelligence or persons who knew the couple well. In effect, despite what was clearly a comprehensive police investigation, they uncovered very little about either of them.

2.21 The police investigation is distinct in that in order to establish a motive and background of each of the persons herein, they create a 'victimology', in essence a fact file in respect of the victim and a 'subject profile' for the perpetrator. The senior investigating officer and case officer both commented to the police IMR author that they had never experienced an investigation where so little was known throughout.

2.22 The engagement of the wider family unit was made with the support of an experienced detective acting as the Family Liaison Officer (FLO) with the same officer supporting the independent overview process.

2.23 The police IMR author also identified that the homicide investigation looked further afield in order to examine the backgrounds of both the perpetrator and the victim, including enquiries in the area that the couple had originated from. This provided little background and no significant historical information with which to assist this DHR.

3.0 Case Analysis

3.1 Comprehensive enquiries across partner agencies in Peterborough have confirmed that the police's initial view that the victim's death appeared to have been as a consequence of an extreme act of singular violence where the perpetrator lost complete control, appears to be accurate, yet unusual in the lack of history. If the victim had experienced previous violence at the hands of the perpetrator, she did not either tell her family or seek advice from agencies that would have been

² The notes from the assessment were not provided to the police at the time and became an issue of non-disclosure at the first trial.

able to help her. She had no apparent close friends with whom she could confide in and certainly made no mention to her sister-in-law. The police enquiries made by their 'house to house co-ordinator', revealed little about the household, to such an extent that the couple appeared virtually invisible to their neighbours. The neighbourhood is multi-cultural and numerous nationalities are represented within the immediate area³.

3.2 It has been established that this was quite an isolated couple who did not have many friends or family and who 'kept themselves to themselves'. In summary of the disclosed mental health assessment, evidence of which was heard in the second trial, it is summarised from the perpetrators perspective that he maintained contact, generally by telephone, with his mother and twin brother who live in Yorkshire and **he considered that his mother and his wife were his closest friends**. He met his wife on a 'blind date'. It appears that having lived together for some time, they got married but that his sexual relationship with the victim declined and they stopped having sexual intercourse, relatively early in the marriage. Neither he, nor his wife sought relationships outside of their marriage which he stated they were both content with. The disclosure suggested that their relationship had not been sexual for a considerable number of years.

3.3 The perpetrator stated that he was fined for an indecent exposure offence some 20 years ago, but both he and the victim "coped well" with this, but he admitted to having continued to 'flash' habitually all his life, but had concealed this behaviour. He did not in fact have any criminal conviction and the extensive police investigation found no reference to this claim. He stated that his sexual problems were of his own manifestation which affected him personally and not his wife. The victim had discovered about his most recent 'exposure' although quite how is not apparent. The perpetrator stated that the victim had told him that if he did not stop, she would leave him but he indicated that this did not lead to the harm to her.

3.4 In essence the assessment identified some complex issues concerning the perpetrator, but little revelation of the victim, leaving a considerable number of questions unanswered, although the focus of the assessment was singular in ensuring the perpetrators suitability to be interviewed and dealt with by the police. In choosing not to speak following this, this was his lawful right and the police and other agencies are bound by law accordingly.

3.5 **It is the view of the victim's family, that even if she had been worried about her husband's violent or threatening behaviour if it was present in the relationship, she would not have sought professional help**. Quite why this is their honestly held belief may conceal the issue of the perpetrators probable coercive control, although this is an observation as opposed to factual.

3.6 However, we have considered whether the victim might have wanted to seek help or advice but found it difficult to know who to approach or did not feel confident to share worries with professionals. In respect of the perpetrator It appears that he was willing to accept offers of support,

³ Evidence from a national social report conducted in 2013, identified that relatively few people know or interact with their neighbours.

as exemplified by the actions taken by his employers, but he appears to have acted alone by taking the decision not to see an independent advocate at the Citizen's Advice Bureau.

3.7 How the perpetrator and victim were sold the mortgage product both originally and in re-mortgaging is a point of some concern. For example, new financial arrangements by the Financial Conducts Authority concerning all mortgage applications did not come into force until 2014. This followed on from research that identified people were being allowed to take on mortgages and repayments that were effectively out of their ability to afford. This of course sits outside of the dates when the respective mortgages were obtained by them, but would have featured in the re-assessment on a new application. What advice they were given at the time in both 1989 and 2007 remains speculative but on a salary as indicated, the impact of knowing that they were unlikely to be able to be able to pay off the capital sum must have been a consideration.

3.8 The fact that the victim, who was in remission from a life changing illness, did not work, was also likely to have impacted on the couples finances. It is not clear whether the victim was unable to work or was prevented from working by the perpetrator, or indeed if this was of her own choice. They did not appear to lead a lavish lifestyle, their home was comfortable and in a reasonable state of repair and the police investigation identified that the income into the household was low. The capital raised by the re-mortgaging in 2007 was it seems used in everyday living. They did not own a car and took an annual holiday on the Norfolk coast.

3.9 Interviews with family members and work colleagues suggest that there had been no apparent previous incidents of domestic violence. All those who knew the couple were shocked and completely taken aback by the homicide. The overview author recognises that whilst this perspective appears to indicate that there was no apparent violence, there may have been an underlying element of control and coercion on the part of the perpetrator where domestic abuse by control, led to the tragic violence.

3.10 The victim's sister-in-law appears from the investigation and DHR consultation, to have been her only confidante. In discussion with her, she did not have any information to suggest that there had been any obvious incidents of domestic violence or that there were any overt marital problems. Both the sister-in-law and the victim's brother were aware of the couple's financial difficulties and had offered advice, although neither had been aware of the full extent of how much the couple owed or how soon the repayment of the mortgage had been due. However, they do both believe that neither of them had fully appreciated the implications of an interest only mortgage when they first took it out. Once the reality of their financial predicament dawned on them, it put them under a huge amount of stress. This remained without resolution.

3.11 The victims' relatives also believe that given that the financial worries appear to have been in existence for some time, it is possible therefore, that there was another, yet unknown trigger for this apparently unpremeditated incident. If this was, as the perpetrator indicated in his disclosure during his mental health assessment concerning his self-admitted 'flashing' (presumably a reference to indecent exposure) there is no evidence of this occurring from the police investigation perspective. This may of course have gone unreported but additionally his perspective on this may be somewhat different to the facts, which he remains silent about.

3.12 Family members are of the opinion that even if the victim was worried about domestic abuse, she would have been very unlikely to have approached an outside agency for advice. They held this view because prior to her cancer diagnosis some years earlier she had had symptoms of the illness for a significant period of time but had continually put off seeking any medical help. She finally did so on the insistence of her sister-in-law, and possibly other members of the family.

3.13 At the time of the homicide in May 2012, work to coordinate and raise awareness of domestic abuse was patchy. The city had been without a Domestic Abuse Coordinator for a period of over two years and consequently awareness raising was not strategically driven and consisted of occasional press releases at times of high risk. For example a press release had been put out to the local radio stations and newspaper to coincide with Valentine's Day earlier that year, and preparations were beginning to raise awareness during the Football European Cup which took place in June 2012. There was also a section on the Community Safety Partnership (CSP) website dedicated to domestic abuse, outlining definitions, safety planning, and help and support services.

4.0 Conclusions and Lessons Learned

4.1 Extensive enquiries have been made across a range of organisations in Peterborough, both statutory and voluntary. None of them had any information to indicate any apparent or possible concern to suggest that victim was at risk either in the immediacy or in the weeks and months leading up to her tragic death. This situation has been confirmed during the comprehensive enquiries made with the perpetrators work colleagues and by the communication and evidence provided by the wider family of both of them.

4.2 The fact that the victim appears to have led such an apparently insular lifestyle is further emphasised by the additional enquiries made with neighbours. It is perhaps a reasonable conclusion to reach that the financial concerns may have been an overarching influence on their lifestyle, not in so much as their day to day living, but in anticipation of what the future held. In essence this was building up to an impasse and despite best efforts of support, the perpetrator appears to have controlled this at the detriment to the victim, who appears to have had little voice from what can be established now.

4.3 The perpetrator has consistently refused to speak about the circumstances of his wife's death and this continues to be the case. Although this indicates the potential of coercion on his part, it is therefore, not possible to ascertain with any degree of certainty what triggered this apparently unpremeditated and catastrophic act of violence, although the stress caused by the financial worries is believed to have been a singularly significant contributory factor.

4.4 The overview author has consulted with the police Senior Investigating Officer (SIO) who has proposed that the perpetrator will be seen, post-conviction, by officers independent of the investigation to establish if he is willing to talk about the tragedy. Those officers will be skilled and accredited interview advisors and practitioners. Whilst this could be considered to be a controversial decision, the police have established a good working relationship with the HM Prison Service and other agencies working with offenders. The Police are involved in providing information relating to

the offence and participate in Multi Agency Lifer Risk Assessment Panels (MALRAPs), shortly after conviction. This has already taken place in this case.

4.5 The police intend to make an enquiry sometime during 2015 that will facilitate them access to the perpetrator with the support of the psychology team at the prison. It is hoped that he may discuss or be willing to consider talking about the wider issues which in turn can be shared, with his consent, to the chair of SPP. This will assist in order to provide a context with which future opportunities to be pro-active in partnership working. This is an aspirational perspective, but the SPP should not be constrained by time when opportunities exist to examine the wider picture in the longer term. This perspective will ensure that appropriate safeguarding considerations can be made where appropriate and emphasises that the partnership work can extend beyond conviction in order to enhance strategy in future domestic abuse planning.

4.6 Given the circumstances, it is the view of the DHR Panel and of the Report Author, that although there are no specific lessons to be learned for those agencies who work together to meet the needs of those at risk of domestic abuse, there remains opportunities to enhance knowledge of coercive behaviour and potential work with other agencies such as the FCA in order to share knowledge and experience.

4.7 Understanding the influences of coercive control or behaviour on the part of a perpetrator, for example the isolation of the victim, restricting daily activities, intimidation and stifling of independence, are elements that may in fact be present in this case, yet not understood or observed. It follows that although there may be a background of violence, this may not always be the case⁴. These are key issues and will of course be subject to the Home Secretary's planned amendments to legislation following recent consultation.

4.8 The Panel did agree that there is a wider lesson to be learned about the impact of financial pressure and that ensuring people are aware of where they can seek advice. The Panel recommend that Peterborough's Welfare Reform Action Group (WRAG) learns from this case and instigates a pro-active campaign within the city to raise awareness of where help and advice concerning financial matters can be made. The objective is to remove or reduce the stigma of seeking such help.

Amendments to the financial arrangements for securing any mortgage in changes introduced in mid-2014 by the FCA (Financial Conduct Authority) mean lenders must ensure borrowers only get a mortgage they can afford. This however is not as strictly regulated for 'interest only' mortgages.

4.9 In May 2012, the city's Domestic Abuse Strategic Board was re-established after an absence of several years. Its aim was to draw together and drive the priorities for addressing domestic abuse across the city on a multi-agency basis.

4.10 Since then, the agenda has moved forward significantly. An initial needs audit was undertaken in the summer of 2012 and was refreshed earlier this year. There is now a city-wide multi-agency Domestic Abuse Strategy, which is overseen by the Community Safety Partnership and domestic abuse is a key current priority of the CSP.

⁴ Stark 2007 and Johnson 2008.

4.11 A Domestic Abuse and Sexual Violence Co-ordinator started in post in September 2013. The post holders remit is to specifically drive the strategy and deliver against an approved action plan. The action plan – drawn up in conjunction with key partners – is designed to address issues raised by the needs audit and to meet the priorities identified in the Strategy both comprehensively and sustainably.

4.12 In addition, there is now a co-ordinated approach to domestic abuse awareness campaigns, with significant work being undertaken to raise awareness of the issue and also publicise the available help and support. For example, a campaign was undertaken in the local media during November last year to link with White Ribbon Day and Domestic Abuse Awareness Fortnight which included posters, social media and a short video. Gaps however still exist in the delivery of domestic abuse training to professionals.

4.13 The overview author has established for example that the GP practice did not have any specific Domestic Abuse training at the time of or before this tragic event, although safeguarding training had been delivered. Part of the on-going strategy is to ensure the delivery of DA training across the wider health sector, in particular with GP practices as they are a key to identifying early warning indicators of abuse. The value of this should not be under estimated.

4.14 The proposed action by the police, in conjunction with the statutory processes that are already under way, is identified as being a real opportunity to improve knowledge for all agencies and is a good example of the importance of partnerships continuing to open doors into cases with the ultimate aim of making communities safer. Understanding more about why the perpetrator acted as he did is the ultimate aim and the panel should encourage such opportunities by looking at the value of integrating post-conviction agencies in the wider scheme to the panel.

4.15 The wider safeguarding partnership in Peterborough have recently established a Multi-Agency Safeguarding Hub (MASH) it is essential that the assessment of risk in relation to DA is included within this MASH. It will really enhance information sharing and the assessment of risk.

4.16 The findings of this overview report are that this tragic death could not have been predicted from the information as was understood at the time. This is an unusual case in that the insular lifestyle of the victim and perpetrator has meant that they have gone about their lives, virtually unnoticed by those who may have been considered to have been close to them. This case may be one with which the Safer Peterborough Partnership wish to consider within future strategies in how to reach 'hidden' individuals who may be in need of support and the awareness of DA made to voluntary agencies where such background may hitherto go unseen or not understood.

5.0 Recommendations

5.1 The overview author makes the following observations to be considered by the Safer Peterborough Partnership in strategic planning to tackle DA.

5.2 Domestic Abuse training should be delivered by the Domestic Abuse steering group to GP practices across the Local Authority area. There is sufficient knowledge and expertise within the existing partnerships to deliver this in the forthcoming year.

5.3 When convening a DHR panel, the panel Chair should extend invitations to both statutory and voluntary organisations where opportunities exist in order to maximise the input from agencies and share relevant knowledge and expertise.

5.4 Consideration is given to continuing the development of the Multi-Agency Safeguarding Hub (MASH) to improve information sharing and include the assessment of risk in relation to DA.

Russell Wate QPM MSc

December 2014.

Restricted