Executive Summary:

Domestic Homicide Review into the Death of 'Michelle'

Date of death October 2016

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COMMISSIONED BY THE BOURNEMOUTH COMMUNITY SAFETY PARTNERSHIP

DATE: 15.1.18

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1. The Review process

1.1 In October 2016 Michelle was found dead from multiple stab wounds at her home address. It is thought she died on the previous evening before midnight. It is believed that her body was partially hidden in a carpet overnight and that this was witnessed by a child. In April 2017 at Winchester Crown Court Simon was sentenced to life imprisonment with a recommendation he serve a minimum of 21 years in custody for the murder of Michelle.

1.2 The pseudonyms used in this review for the victim is Michelle and for the perpetrator is Simon, Michelle was chosen by the victim's mother and these are being used to protect the victim and their family. Michelle was 26 years of age and identified as white British, she had no known disabilities, she had worked for an Insurance company and was about to start a new role at a Building Society. Simon at the time of the murder was 26 years of age and identifies as white British with no known disabilities, he had worked as a manager at Tesco's and was at the time of the murder serving in HM Army.

1.3. The initial investigation identified that domestic violence did play a significant part in this death. For that reason and in accordance with the statutory Guidance relating to Section 9 of the Domestic Violence, Crime and Victims Act (2004), Bournemouth Community Safety Partnership commissioned a Domestic Homicide Review (DHR) in November 2016. The decision was made to separate the roles of Chair and author of the Domestic Homicide Review.

1.4 All agencies that potentially had contact with Michelle or Simon and their children prior to her death (seven agencies) were contacted and asked to confirm whether they had any involvement with them and if so to secure their records of this contact. The panel then requested four Independent Management Reviews from these agencies. As Simon was currently serving in HM Army, information was requested from them and the Police Force of the area he was stationed in. This information was included in Dorset Police Independent Management Review.

2 Contributors to the Domestic Homicide Review

2.1 Agencies represented on the panel and those that provided information for the review

Agency Representative	Name	**Role**	Independent Management Review provided
Independent	Tonia Redvers	Chair	
Independent	Jan Pickles OBE	Author	
Dorset Police	Stewart Balmer	Force Review Officer, Dorset Police	Yes Included information From Devon and Cornwall Police Force
Community Safety Partnership Officer, Bournemouth Borough Council	Sîan Jenkins	Link to Community Safety Partnership	Provided background information from Bournemouth Children's Services
Named Nurse & Lead Safeguarding Children, DHUFT	Liz Balfe replaced by Janice Carswell for final part of review	Panel member	Yes
Head of Quality Improvement, Quality Directorate, Dorset CCG	Pam O'Shea	Panel member	Yes
Bournemouth & Poole Adult Safeguarding Board	Anne Humphries (for the first 2 meetings only)	Panel member	
Dorset Police	DCI Joan Carmichael , replaced by DCI Gavin Dudfield part way through review	Adult Public Protection, Dorset Police	Yes
HMPPS	Tina Ridge	Head of Dorset National Probation Service	Yes

Dorset Police	Caroline Garrett	Note Taker, Dorset Police	
MOD	Dr. Douglas Reid	Army GP - Attended May 2017 Panel meeting only	Provided verbal only information to Panel in May 2017

In May 2017 information was requested from one of the children's school as the Panel became aware of a relevant disclosure made by Michelle's daughter. This report was received in late July 2017and had been prepared by the Head of the Primary School and not an independent person. This was because the disclosure had gone no further and therefore the most senior person at the school was asked to report to the Panel.

Information was also requested from the British Pregnancy Advisory Service who had contact with Michelle.

2.2 Independence of Panel members and Independent Management Review authors

All Panel members and Independent Management Review authors had not been in direct contact with Michelle or Simon or their children or supervised staff who had any direct involvement with them.

2.3 Independence of the Chair of the Domestic Homicide Review

The Review was Chaired by Ms Tonia Redvers. She is the Head of Domestic Violence and Abuse Services at the YOU Trust, a specialist domestic abuse service in an adjoining area and has not worked for any of the agencies involved.

2.4 Independence of the author of the Domestic Homicide Review

The panel first met in May 2017. I was appointed as author of the Domestic Homicide Review and as the independent person whose role was to liaise with family members in June 2017. I attended my first meeting in July 2017. I am a qualified and registered social worker with over thirty-five years' experience of working with offenders and victims of domestic abuse and sexual violence, both operationally and in a strategic capacity. In 2004, I received an OBE for services to victims of domestic abuse for the development of both the Multi Agency Risk Assessment Conference (MARAC) model and for development of the concept of Independent Domestic Violence Advisers (IDVAs). In 2010, I received the First Minister of Wales' Recognition Award for the establishment of services for victims of sexual violence. In my career, I have held roles as a Probation Officer, Social Worker, Social Work Manager, Human Rights Charity Director, Assistant Police and Crime Commissioner and as a Ministerial Adviser in Government. I currently am an Independent Board member on a NHS Trust and a member of the National Independent Safeguarding

Board for Wales. I have completed the Home Office training for chairs and authors of Domestic Homicide Reviews.

I was not currently employed by any of the statutory agencies involved in the review (as identified in section 9 of the Act) and have had no previous involvement or contact with the family or any of the other parties involved in the events under review.

3. The Terms of Reference of the Domestic Homicide Review

Whilst respecting Michelle and her family the review sought to do the following:

- Consider the period of thirty months (June 2013 - October 2016) prior to the death of Michelle subject to any information emerging that prompts extending the review to earlier incidents or events
- Consider the way in which information was exchanged between agencies
- Request Independent Management Reviews from each of the agencies defined in Section 9 of the Act and to invite responses from any other relevant agencies or individuals identified through the review process;
- Seek the involvement of the family and relevant friends and the perpetrators to provide a robust analysis of the events;
- Take account of the Coroner's Inquest, criminal proceedings and other relevant enquiries.
- Produce a report that summarises the chronology of the events, details the actions of the agencies involved with analysis and comment, and makes recommendations for safeguarding individuals where domestic abuse is a feature;
- To aim to produce a final report by the end of November 2017. The final report will be shared with family members prior to being presented to the commissioning authority Bournemouth Community Safety Partnership. Once accepted by the Bournemouth Community Safety Partnership the report will be submitted to the Home Office for quality assurance and then published in such a way that will respect the family's privacy.

4 The Summary Chronology

4.1 At the time of her death Michelle was a 26-year-old woman who was a loving mother to two small children, her daughter and her baby son. Michelle was a victim of repeated violence and abuse at the hands of her partner and had also been a victim of violence from her previous partner. Michelle struggled emotionally as a teenager and this resulted in conflict in the family home. Concerns about her low mood, self-harm and suicidal feelings were documented. Many years before her death Michelle had repaired her relationship with her parents and was very close to them.

4.2 The perpetrator, Simon grew up in a family in which violence was endemic and seen as an acceptable means of resolving issues. Simon's parents separated when

he and his brother were small children. Simon's mother moved to Australia a few years ago. Their father had served in the Belgian Army and Social Work records from 2004, when Simon and his brothers were aged seven to eight years old, note that weapons such as knives and an axe were accessible to them in their father's home. His father made a point of showing the children how to use knives and they were routinely left around the house. Simon and his siblings all have criminal records and a reputation within the area for violence involving partners, family members and the public.

4.3 Although the terms of reference for this review were limited in time to the thirty months preceding her death, her biological father believed Michelle's low self-esteem as an adolescent was a significant factor in her repeatedly finding herself in and remaining in abusive relationships, this was not a view shared by her mother who describes her as insecure but confident. Her relationship prior to her meeting Simon had resulted in numerous Police call outs and contacts with Health Visitors but at no point could the Panel establish that Michelle had received any domestic abuse advice or a referral to specialist domestic abuse service.

4.4 After nearly a year of being on her own in 2013 Michelle met Simon whom she had known from school, and according to her mother, father and friend Rachel "fell head over heels for him". Michelle was working for an insurance company and she is described as a very able mum to her daughter. The couple both had daughters from previous relationships. Michelle felt immediately close to Simon as they both had something in common in having a young child. Simon was working in Tesco's as a manager and was keen to better himself and fulfil his lifetime ambition of joining the army

4.5 Michelle's mother felt that the relationship with Simon was 'tempestuous' from the outset with Michelle discovering him accessing pornographic websites on his laptop and evidence of him visiting prostitutes. Their relationship was marked by a pattern of brief break ups and reconciliations, with regular arguments and Michelle always suspicious of him being unfaithful. She often checked his phones etc. for evidence of affairs. However, her mother and step-father believe she was drawn to Simon due to his desire to better himself, that he took responsibility for the care of his child even after he had separated from the mother, despite his vulnerability due to difficult family life and childhood. Michelle would repeatedly return to him following any separation during this period.

4.6 Simon had been abusive to a previous partner the full extent of it only emerged after Michelle's death. Simon joined the Army in 2015 and was stationed in Plymouth returning to be with Michelle during his leave periods. During this time, Michelle became pregnant with Simon's child. Michelle's friend described the pregnancy as Simon's way of keeping Michelle. Michelle's parents describe how Michelle hoped they would marry and live in an Army house with their children.

4.7 The relationship between Michelle and Simon was not known to Services to be abusive until a Police call out in March 2016. Michelle had made that call to the Police, initially a silent call, as she wished Simon to leave the home as he was drunk. What has emerged as a result of the investigation since Michelle's death has been a catalogue of serious violence carried out by Simon, some of which was experienced and witnessed by Michelle, possibly the baby boy and significantly Michelle's daughter, who witnessed a protracted and serious fight between Simon and his twin brother, in the family home. After this incident, which one can assume to have been traumatic and long lasting in its effects on her, Michelle's daughter was brave enough to disclose the violence to a teacher at her school. It was dealt with as an internal matter and the information not shared with the relevant services as it should have been in line with statutory Child Protection Procedures.

4.8 Michelle and Simon separated in early summer 2016. Michelle's family describe Michelle as slowly beginning to recover from her relationship with Simon. She found a new job, flat and a car with their help and started to make a new home for her and her two children. However, despite now having a close and loving relationship with her family, she was lonely. Her family believe she had lost many of her friends due to an argument with friends and Simon's behaviour. This is reinforced by Rachel who stated he had actively worked to isolate her from her circle of friends. This isolation was compounded as Rachel had moved away from the area, and the demands of two young children left her with little time in any event. Michelle felt, according to her father, that she would often not be invited to social events even after she and Simon had separated due to the fear people had of him. This, her parents believe increased her sense of loneliness significantly.

4.9 Michelle's family believe that Simon, after the separation, was slowly working to regain Michelle's trust, this was helped by the fact he was a dutiful father and that they would all go on family outings together. This arrangement slowly developed into one in which Simon would baby sit whilst Michelle went out with friends, and he would stay overnight at Michelle's flat. Michelle's parents later found out, as Michelle had never told them, that she and Simon had resumed a physical relationship. They believe that during this time Michelle wanted Simon and her to reconcile and become a family again.

4.10 Simon's Army career appears to be a significant factor in this review. Simon had for several years a strong ambition to join the Army. Despite his history of violence and interest in Nazi memorabilia he was accepted by the Army as a Gunner and undertook training for the Marines. Although he failed the Marine training, Simon was keen to try again. The Army were aware that he had issues with his brothers and his use of alcohol and the combination of these could result in violence but felt these were manageable. This remained the position following an assault of two unknown males in a Nightclub in Plymouth in October 2015.

4.11 One significant factor appears to have been a rape allegation that was made against Simon and an Army colleague. The alleged Rape occurred in May 2016 and following an unsuccessful initial investigation Devon and Cornwall Police released an image to which Simon and a colleague responded in early August 2016, he was interviewed in August 2016 by Devon and Cornwall Police. Michelle did not know of this Police investigation but was made aware of it on the day of her death. On this day Simon was notified that his bail was being cancelled and Michelle herself researched local press coverage shared on social media. Michelle was distressed and angry. She called a friend of Simon's about the allegations and left an angry voice mail message. She told her mother who was away on holiday by phone and text of her intent to challenge Simon about the allegations she had heard. At this point, Simon was at Michelle's home. Michelle's mother says this call was made at 10:55 pm and that she was killed five minutes later. Michelle's mother believes this indicates that Michelle did challenge Simon about the rape allegations and that this led to her death. Whether she did this is not definitively known and could only be confirmed by Simon who has refused to co-operate with this review

4.12 Much of Simon's abusive and violent behaviour to Michelle was not known until the trial, it was not shared by family and friends prior to this and so a true picture was not available to services involved at the time. It seems that Simon targeted family members, Michelle's and his own, friends and members of the public not known to him in random, apparently unprovoked attacks. Alcohol was often but not always present as were emotional factors such as possessiveness, frustration, anger and jealousy. Michelle's father felt that his violent behaviour often "came from nowhere".

5.Key issues arising from the Review

5.1 Michelle's lack of confidence in services and services ability to engage with her and offer her domestic abuse advice.

Michelle was referred to Community Adolescent Mental Health Services in 2006. However, the Service was unable to engage her in working with them. At that time Michelle felt services were of no use to her and this experience may have led to her feeling indifferent towards or suspicious of help from state services. Additionally, as a victim of domestic abuse at the hands of her previous partner we do not know the impact on Michelle when Social Services closed her case despite her having a young baby. It is worth noting that she was not referred to a specialist service where she may have received useful information and/or support. Services knew she was a repeat victim of domestic abuse and they should have the skills to seek to engage with those who may appear hard to reach or even actively hostile. This review has identified that Michelle kept Simon's violence hidden so he could join the army. Family and friends also were persuaded to collude with this for fear of damaging their relationship with Michelle, and in the hope that once he was away in the army she may move on and leave him.

5.2 Michelle's isolation, confidence and low self-esteem.

Michelle has been described to me as a beautiful young woman who throughout her adolescence and early adult life appeared to have thought little of herself. The family believed she was a strong and feisty young woman and it would appear services also viewed her in this way too failing to respond to her as a victim of domestic abuse in her previous relationship. It would appear to all her family that on the night of her death Michelle had no idea of the danger she was in as she challenged Simon over the rape allegation.

5.3 Early opportunities to inform Michelle about the nature and dynamics of domestic abuse.

Michelle met her previous partner in 2008; he was repeatedly abusive to her, this was known to the Police and Health Visiting Service and did not lead to a referral to a specialist domestic abuse service .That partner attended an Integrated Domestic Abuse Programme run by the Probation Service but due to their destruction of records policy, the review has no knowledge of a service being offered to Michelle by the Women's Safety Worker attached to the Programme. This is critical as it may have been the only specialist domestic abuse advice Michelle was offered. As the family believe her lack of understanding of the risks she faced led to her death. Specialist domestic abuse advice may have helped her identify risk.

5.4 Health Services.

As stated the ongoing abusive nature of Michelle's relationship with her previous partner did not result in Michelle receiving domestic abuse specialist advice from Health or any other agency despite being a young mother living in an abusive relationship with a young baby and therefore vulnerable.

Simons violence and abuse was hidden from services until a Police call out in March 2016 identified that the children were present during a verbal altercation between Simon and Michelle. This was only followed up by an unsuccessful phone call from a Health Visitor, despite an infant under one year being present. At a later opportunity in August 2016 when Simon brought the baby to clinic the issue of his abusive behaviour was not raised with him, because the training the Health Visitor had received advised against this. This was to be the last contact by Health before the death of Michelle. The model of 'Making every contact count' may prove useful, as may training to increase skills and confidence in talking to men about the impact of their domestic abuse on their children.

The Police notifications 'SCARF' are routinely shared with the relevant Health agency. The Independent Management Review from Dorset Health identified at the time that the GP may not have had sight of the repeated SCARF notifications on their computer system. Due to this review that has now been remedied.

5.5. Probation.

Michelle's previous partner was sentenced to Probation Supervision and attendance on the Service's Integrated Domestic Abuse programme (IDAP). As part of that programme a Women's Safety Worker (WSW) should contact the named victim, and if consent is gained engage with them and ensure that her safety is monitored during the Programme. However, the Probation Service could not confirm whether Michelle was visited by the WSW or not. This information is key as attendance on Programmes such as IDAP can impact on risk in terms of increasing or decreasing the risk to the victim. In Michelle's case, it may have been the only opportunity the review has identified that she could have met with a specialist domestic service.

5.6. The school.

Michelle's daughter shared a serious violent incident (at home) in her school initially with a friend and then later with a staff member. She disclosed to the staff member specific details such as the adults fighting, the presence and amount of blood and the proximity of the violence to her. She stated when questioned that it had all happened a long time ago. This disclosure was dealt with as an internal matter and the information not shared, as it should have been in line with 'Working Together' the National Child Protection Procedures. It seems that the school at the time took at face value the assurances that Michelle provided when spoken to by the school that such an event would never happen again. The School Nurse was informed of a later domestic abuse incident via the SCARF in March 2016 and this did not lead them to reconsider and refer the earlier disclosure.

5.7 Police-The level of ongoing violence in the wider family and community.

The violence within Simon's family does not seem at any point to have been treated as serious or looked as a whole by the services involved. The violent incidents within the family meet the Home Office Definition of Domestic Abuse and should have been risk assessed and information shared as such. This would have identified Michelle and the children in the home as at significant risk. Although Michelle did not report his violence, it was known that Simon had been violent and abusive to his former partner and Michelle's father, unknown members of the public and a female friend of Michelle's in a local night club. These violent events were either not reported or minimised. The motives for this silence are not clear. One possibility may be loyalty to either Simon (protecting his army career), Michelle or of course fear of Simon and his violence. However, both explanations fall into the definition of 'coercive control'.

5.8. The impact of the Rape allegation.

Michelle did not know of the Police investigations, but on the day of her death became was aware of the rape allegation involving Simon. She texted a friend and his brother, appearing angry and distressed and told her mother, who was out of the country on holiday, by phone that she intended to challenge him about his as soon

as she saw him. Whether she did is not known, nor is the effect that the allegations and Michelle's knowledge of them had on the events leading up to her death.

6.Conclusions

6.1 Early intervention by Health.

Michelle was seen by a range of Health Services, the Health Visiting Service, her GP, Sexual Health and the British Pregnancy Advice Service. These services are not co located and do not all receive SCARF notifications. For instance, at the time Michelle's GP did not have access to them. In reality this meant that no individual Health service had a full overview of Michelle's situation.

Although outside of the terms of reference I note that when Michelle gave birth to her first child then aged eighteen years old in April 2009, Health Visitors were aware of eight incidents of domestic abuse via the SCARF system within the first eighteen months of her daughter's life which clearly identifies Michelle as a victim of domestic abuse.

During the scope of the review Michelle was seen on six occasions by the Health Visiting Services who had again became involved with Michelle in August 2015 when she became pregnant with Simon's baby. It was recorded then that she was a previous victim of domestic abuse. The link between Michelle as a previous victim and Simon being a perpetrator in a previous relationship was not made as the record keeping for Health Visiting follows the mother and so does not allow the Health Visitor to monitor serial perpetrators who have children with new partners.

At no point was a DASH undertaken by a Health professional with Michelle who was seen as initially "quite hostile but did eventually become engaged". She was seen as "mistrustful of professionals and displayed superficial engagement". The principles of Disguised Compliance where not referred to in the recording of contact or the Independent Management Review.

6.2 Dorset Police.

During Michelle's previous relationship, the Police were called on numerous occasions and did not manage to engage Michelle. During Michelle's relationship with Simon there were missed opportunities to complete SCARFs and/or DASH forms and a slow response to an incident where an infant was involved, with the Police attending eighteen hours after it being reported.

Simon was also threatening and violent away from the home. To ensure Police Officers make the link between violence outside of the home and domestic abuse in the home, a reminder has been issued to all staff following this case. This is to encourage those who are dealing with violent behaviour in the night-time economy to consider the partners and children they may return home to.

6.3 Devon and Cornwall Police.

Following a press release with information about the alleged Rape in Plymouth, Simon and an Army colleague contacted Devon and Cornwall Police. They were offered an appointment for an interview with the Police thirteen days after their call. In the meantime, no attempt was made to collect any potential evidence, such as their phones or a search within the Barracks. However, the Review understands that at the victim's request an internal review of the case under the Victims Right to Review supported the outcome of the Investigation.

6.4 Education .

A significant disclosure was made to school staff by Michelle's daughter. This disclosure was not dealt with according to the statutory guidance 'Working Together to Safeguard Children' or in line with the 'Keeping children safe in Education' Statutory guidance both issued in March 2015 by the Department of Education. A referral to Children's Social Care was not made as it should have been.

That the school believed Michelle's response to their concerns that she was able to control her partner's behaviour and prevent any future violence, and keep her children safe, demonstrates a very limited understanding by staff at the school of the nature and dynamics of domestic abuse.

The Review Panel are aware though the School's IMR response that a lack of awareness of the dynamics and prevalence of domestic abuse still exists within the school. It is also concerned that assumptions about prevalence being linked to socio economic and cultural factors continue and could lead to further instances not being identified correctly and speedily by the school

6.5 The National Probation Service.

As all records related to the role of Women's Safety Worker are destroyed after five years, the review has been unable to address if Michelle engaged and the value of such support. This would have been the only contact Michelle had with a specialist domestic abuse service and opportunity to receive specialist advice designed to ensure her safety.

6.6 Children's Social Care.

Children's Social Care had little contact with Michelle during the period identified by the Terms of Reference of this review. They were not asked to provide an Independent Management Report, so I am unable to comment on the work undertaken by them. They would have received repeat SCARFs from the Police during Michelle's relationship with her previous partner and are referred to in the Health Visitor notes as closing a case due to Michelle's lack of co-operation.

6.7 Family and friends.

This review has identified that Michelle's low self-esteem coupled with a lack of knowledge about the risks she was living with meant that she remained in and

endured these abusive relationships. Her family and friends also had limited knowledge of the dynamics of domestic abuse, perceiving her as strong and therefore not a victim. The pressure from Michelle to collude was great, whether motivated by her fear of him or of losing him. The family feel that had they known more about the coercive control element of domestic abuse they may have intervened.

7.Lessons to be learned

7.1 Michelle's family and friends knew little of the dynamics or impact of domestic abuse and recognise the need for local publicity campaign to educate the public especially on the nature of coercive control is and why it is so dangerous. They believe families need to know what they can do to protect family, friends, colleagues or others if you suspect they are in an abusive relationship.

7.2 Michelle's lack of self-confidence and low self-esteem suggest her own education had not equipped her to understand her value and the right she had to respectful relationships.

7.3 The disclosure made by Michelle's daughter was not appropriately acted on by the school which later demonstrated a lack of understanding of the prevalence of domestic abuse.

7.4 Health Visitors need to know how to 'ask and act' about domestic abuse and their management are confident that staff can discuss these issues safely with patients known to be victims and/or perpetrators. The current training on engaging potential perpetrators of domestic abuse to be reviewed as this review has identified current training advises professionals not to address domestic abuse with the perpetrator even when they have been notified officially by the Police of a recorded incident.

7.5. At the time the GP was dependent on the Health Visitor for knowing Police call out information, recent changes separating Health Visitors from GP Practices will mean the GP will no longer be able to rely on Police information being shared through this route. Therefore further reassurance is necessary that a route of communication from the Police to GP practices will imminently be in place.

7.6 The Dorset Police Service was aware of Simon's wider violent behaviour and that there was a pattern of many alleged victims - partners, family members, friends and members of the public. All chose not to report incidents they were aware of either as victims or witnesses. The Police Service had contact with Michelle over several years and during these contacts was unable to engage her. That SCARFs were not completed as they should have been meant that the Maple project, the current victim response would not have contacted Michelle.

8. Recommendations from the Review

8.1 A campaign to educate and raise public awareness to enable early identification by potential victims, friends and family of risk factors and signs of abusive, controlling and coercive behaviour.

8.2 The Local Safeguarding Children Board (LSCB) strongly encourage the promotion of Healthy Relationship Education within the curriculum so that all young people in the area receive age appropriate education on healthy relationships and use the annual safeguarding audit process to provide quality assurance.

8.3. The Local Safeguarding Children Board (LSCB) work in partnership with schools and Academy Trusts to ensure that the relevant Safeguarding legislation and guidance are followed. In addition, that any local well-being initiatives introduced to secure the safety and well-being of children in their care do not comprise nationally agreed procedures.

8.4 Health Service agencies adopt best practice for the assessment and management of domestic abuse.

8.5 All GP practices across Dorset, Bournemouth and Poole to identify a lead for domestic abuse within the surgery and to embed the RCGP domestic abuse pathway.

8.6 Dorset Police review police non-engaging victim procedure to provide clarity on how police identify, assess and manage a repeat domestic abuse victim where either the police are not able to offer a service that the victim can engage with or the victim is not able to engage with the service offered. Procedure to cover the roles and links between initial response, investigation, Maple Team and referring to wider partners.

8.7. The Ministry of Justice review the storage policy of Women Safety Worker records