Bournemouth Community Safety Partnership

Domestic Homicide Review Overview Report:

EXECUTIVE SUMMARY

<u>'Marie'</u>

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Executive Summary

1. The review process

This executive summary outlines the process undertaken by the Bournemouth Community Safety Partnership domestic homicide review panel in reviewing the circumstances of the death of ‘Marie ’ at the hands of her bigamous husband, Perpetrator A.

Pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members.

Criminal proceedings have been completed; Perpetrator A has been convicted of murder and sentenced to life imprisonment. He must serve at least 25 years before he becomes eligible for parole. During the investigation it became apparent that Perpetrator A’s wife Perpetrator B and their son Perpetrator C had also had peripheral involvement in Marie’s death. Perpetrator B was found guilty and sentenced to three years in prison for assisting an offender and perverting the course of justice. Perpetrator C was sentenced to two years in prison after he was found guilty of assisting an offender.

When Marie was reported missing, the police were highly suspicious and they arrested the three perpetrators; Marie’s body was found in the boot of a car belonging to Perpetrator C.

Following Marie’s murder and the decision to undertake a Domestic Homicide Review agencies were asked to review their records to establish any contact with Marie and/or Perpetrator A and his family. None of the statutory partners or domestic abuse agencies that make up the Bournemouth Community Safety Partnership had any record of domestic violence and abuse incidents between Marie and any of the Perpetrators.

The DHR panel determined that the review should focus on the period between the 1st January 2005 and 23rd May 2014 including details of any other relationships they may have been in. The purpose of examining their respective previous relationships was to ascertain whether there were any patterns of behaviour that could have a bearing on Marie ’s death. Jane Ashman, Independent Chair of the Dorset and Bournemouth & Poole Safeguarding Adult’s Board was appointed Chair of the review. Following a competitive process, Johnston and Blockley Ltd was commissioned to produce the Overview report.

<u>Agencies making up the panel included</u>

- Dorset Police
- Royal Bournemouth and Christchurch hospitals NHS Foundation Trust
- NHS Dorset Clinical Commissioning Group (Acting on behalf of Primary Care GP's)
- The You Trust (Independent DA adviser)
- Community Safety Partnership, BBC
- Southampton University (Advisor on Chinese cultural issues)
- Service Director, Adult Social Care, BBC
- Head of Patient Safety and Risk, NHS CCG
- Safeguarding Adults Lead, DHUFT

Only Dorset police had any information pertaining to domestic abuse and this information was not connected to Marie

The police

There were several interactions with all three Perpetrators involving domestic violence going back to 2007, Marie did not feature in any of the incidents and Dorset Police were unaware of her and her association with the Perpetrators at that time.

Royal Bournemouth and Christchurch hospitals NHS Foundation Trust

They have no information relating to Marie, or any of the perpetrators that could have any bearing on this review

NHS Dorset Clinical Commissioning Group (Acting on behalf of Primary Care GP's)

They have no information relating to Marie, or any of the perpetrators that could have any bearing on this review

Summary of chronology

Marie and the perpetrator met sometime in 2005 and they were married in July 2007. Unknown to Marie, the marriage was a bigamous one as Perpetrator A was already married to Perpetrator B.

At the time of her death, Marie was a Staff Nurse at a local hospital and had been employed there since 2009. Her colleagues at the hospital said that Marie was extremely well liked by staff and by patients. She had a good sense of humour and was described as being very loyal, a hard worker who was always punctual and someone who was prepared to cover for any staff absences. However, one colleague in particular told the police that Marie would often receive angry phone calls from

Perpetrator A. He would call on the ward telephone because her mobile would have been switched off.

The colleague added that there always appeared to be an element of friction - or an atmosphere between Marie and Perpetrator A and that Marie didn't like leaving work if she knew that Perpetrator A was at home with her daughter. She went on to say that Perpetrator A and Marie’s daughter didn't get on and would have horrendous rows. The cause of the rows appeared to be that Perpetrator A felt that Marie’s daughter was too westernised and that she should do the housework and help more.

When Marie attended social functions on her own she would dress conservatively; her dress would be of a decent length and her legs and chest area would be covered. However when Marie attended functions with Perpetrator A, colleague’s noticed she dressed provocatively.

Marie’s daughter described Perpetrator A as controlling, he would not let Marie meet with her friends and if they did as a couple he would say he did not like them. He did not like Marie and her daughter spending time together and she described that he was always there when she met her mother.

During the police investigation into her death, witnesses gave evidence that Marie had been providing massages from a property she owned and that sometimes sexual services had been included. On occasions Perpetrator A had also been present and had participated.

As the investigation progressed further witnesses were identified, one of which provided evidence that a week before Marie ’s murder there was a meeting between the three conspirators during which the plot to kill her and claim the life insurance was hatched. During the trial, the court was told that Perpetrator A’s plan had been to bury Marie under the floor of a home they were renovating; he had purchased five bags of cement for that purpose.

2. Key issues arising from the review

A number of key learning points have come from this review. Firstly, the impact of culture on identifying and reporting domestic violence and abuse. It is very difficult to break down cultural barriers but it is important that anyone involved in domestic violence and abuse are aware of the cultural barriers to reporting.

Colleagues of Marie had information that could have indicated domestic violence and abuse. It is recognised the challenges of colleague disclosures but all staff should be aware of the signs of coercion and control, recognising it is not only in clients/patients and other service users, but within colleagues and staff.

Throughout the review there is information that indicates Marie was isolated from the general community. She did not appear to have friends outside work and her daughter spent a lot of time with her boyfriend. Indeed, when Marie and her daughter were together Perpetrator A was always with them. It appears this isolation continued in the workplace, as although she sometimes had social contact with colleagues, none would be considered a friend.

This isolation is one of the key learning points and particularly relevant in respect of the increasing numbers of foreign nationals coming to work in the NHS and other industry. It is important to recognise their vulnerability through isolation and understanding acceptable behaviours within the British culture and the UK legislation.

Threat of deportation is a significant controlling behaviour and one that can be easily applied to non-UK residents. The learning from this review should be to raise awareness in communities that domestic violence and abuse is not tolerated within the UK and that they should report such matters to agencies without fear of deportation.

3. Conclusion from the review

Marie had suffered an abusive relationship over many years, with Perpetrator A subjecting her to humiliating behaviours, controlling what clothes she could wear and how she should behave in public. She suffered isolation and sexual abuse throughout the relationship and he demonstrated his power over her at all times cutting off any support networks she may have formed.

The review has not identified anything that would have indicated the dreadful events of May 2014 were likely to happen. None of the agencies that make up the Bournemouth Community Safety Partnership nor Marie's family had any inkling that she was or would become victim of domestic violence or abuse. The Panel is of the view that the homicide of Marie could therefore not have been predicted or prevented.

4. Recommendations from the review

- To examine and assess the current process for integration of foreign nationals into the NHs and other employments. This should include an assessment regarding their cultural vulnerability and staff should be aware of the additional signs and indicators of domestic abuse with relevant policies and guidance to ensure the support and safety of such persons.

- To examine the current strategy with regard to identification of domestic abuse and violence within cultures in the Bournemouth Community Safety Partnership area. To enhance the provision of information and encourage support to those effected by domestic violence and abuse.

- All staff should be aware of incidents of coercive and controlling behaviours as well as the wider domestic violence and abuse within colleagues and there should be a mechanism for reporting concerns and/or suspicions to enable support to those colleagues