

**Domestic Homicide Review**

**Executive Summary**

**Report into the death of ‘Anna’ in June 2016**

**Author:** Victoria McGeough

**Report Completed:** January 2022

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1. **A MESSAGE OF CONDOLENCE**

The Domestic Homicide Review Panel and the members of the Torbay Community Safety Partnership would like to offer their sincere condolences to the family and friends of the victim for whom this Review has been undertaken.

1. **THE REVIEW PROCESS**

This summary outlines the process undertaken by the Torbay Community Safety Partnership (CSP) Domestic Homicide Review Panel in reviewing the homicide of Anna (pseudonym) who was resident in their area.

In this review the pseudonym of ‘Anna’ has been used for the victim and the pseudonym of ‘Tom’ has been used for the perpetrator. This is in order to protect their identities and those of their family members. All other details are an accurate reflection of the case.

Anna was Polish and aged 30 at the time of her death and Tom was Grenadian and aged 22 at the time of Anna’s death.

Tom was arrested and charged with Anna’s murder, however, was found deceased in his prison cell in September 2016, having taken his own life whilst on remand before he could stand trial for Anna’s murder.

An inquest into Anna’s death took place on 19 December 2016, with a conclusion that Anna was unlawfully killed, and a medical cause of death being cited as stab wounds to the neck and abdomen.

The process began with an initial meeting of the Torbay Community Safety Parentship Domestic Homicide Review Panel on 26th September 2017 when the decision to hold a domestic homicide review was agreed. The delay in the Torbay Community Safety Partnership considering Anna’s case for a DHR was caused by ongoing criminal justice processes and inquests that, in the view of the CSP, meant that a DHR could not be effectively progressed earlier.

On agreement to progress with the DHR, all agencies that potentially had contact with Anna and/or Tom prior to the point of death were contacted and asked to confirm whether they had involvement with them.

2 of the 9 agencies contacted confirmed contact with Anna and/ or Tom and were asked to secure their files.

The request for information from partners determined that both Anna and Tom had had minimal contact with agencies. As a result of this it was agreed by the core group that no Independent Management Reviews (IMR) would be commissioned as part of this DHR as initial information had already been obtained through the referral process.

It was agreed the role of chair and author of the Overview Report would be undertaken by the Partnership Lead Manager for the Torbay Community Safety Partnership, supported by the core group, all of whom had no previous contact with or knowledge of Anna or Tom; nor had they worked with any agency that had any contact with Anna or Tom.

This approach was discussed with a domestic abuse representative in the Home Office, following which the core group were confident to proceed and maintained oversight of the completion of the DHR within quarterly core group meetings.

1. **CONTRIBUTORS TO THE REVIEW**

Agencies and other contributors to the review and the nature of their contribution are listed below:

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| **Agency** | **Contribution** |
| * Devon and Cornwall Police | * Report |
| * Torbay Council Housing Department | * Information |
| * Multi-Agency Safeguarding Hub | * Report |
| * South Devon and Torbay Clinical Commissioning Group (CCG) – in line with the locally agreed protocol the CCG collated and provided all the relevant health information in this case information was obtained from the GP, Torbay and South Devon Foundation Health Trust and the Sexual Health Service | * Report |
| * Torbay Domestic Abuse Service | * Information |
| * National Probation Service | * Report |

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| --- | --- |
| **Other key contributors** | **Contribution** |
| * Anna’s sister | * Information |
| * Anna’s friends | * Information |
| * Anna’s employer | * Information |

1. **REVIEW PANEL MEMBERS**

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| --- | --- | --- |
| **Name** | **Role** | **Organisation** |
| Alexandra Stuckey | Partnership Lead Manager (Chair) | Torbay Council |
| David Parsons | Anti-Social Behaviour and Vulnerability Manager | Torbay Council |
| Delia Gilbert | Designated Nurse for Safeguarding Adults | NHS Devon Clinical Commissioning Group |
| Dean Bassett | Detective Inspector | Devon and Cornwall Police |
| Jason Preece | Domestic Abuse and Sexual Violence Co-ordinator | Torbay Council |
| Nariman Dubash | Senior Probation Officer | Dorset, Devon and Cornwall Community Rehabilitation Company |

All of the members confirmed at the start of the process that they had no prior knowledge of Anna or Tom, either personally or professionally.

The panel considered the inclusion of a specialist domestic abuse agency to provide a specialist lens to the review. Unfortunately, due to changes in the local provider service, it was not possible to identify an individual to support. However, the Domestic Abuse and Sexual Violence Co-Ordinator had just been appointed into post from his former position as the Service Manager of a local domestic abuse service. As such it was felt by the panel that this individual would be able to provide the specialist view of a domestic abuse service.

1. **CHAIR AND AUTHOR OF THE OVERVIEW REPORT**

The chair and author of the Overview Report was Alexandra Stuckey. At the time of writing the Overview Report the Alexandra Stuckey was employed as the Partnership Lead Manager for Community Safety by Torbay Council after commencing post in July 2017.

As outlined above it was agreed by the core group after consultation with the Home Office that due to the limited contact both Anna and Tom had had with agencies and independent chair/ author would not be appointed.

The author was not in post at the time of Anna‘s death and had not worked within any of the services who had contact with either Anna or Tom. The panel were assured that the author had no prior knowledge of Anna or Tom before commencing this review.

The author qualified as a Probation Officer in 2002, working initially within Greater Manchester area before transferring to Devon and Cornwall in 2005. The author worked as a specialist Pre-Sentence Report writer in cases of Domestic Abuse and Sexual Violence and was a Domestic Abuse trainer, before becoming a Senior Probation Officer in 2011, and working at an operational management level within a number of areas where there was a prevalence of domestic abuse including the Magistrates Courts, prolific and priority offenders, drug related offending, accredited programme delivery, offender management and public protection. The author was a Multi-Agency Public Protection Arrangements (MAPPA) chair within South Devon at level 2, overseeing and providing coordination of a number of high risk domestic abuse cases.

The author progressed to becoming the MAPPA Coordinator for Devon and Cornwall, overseeing cases at Level 3 and had oversight of a number of complex and very high risk domestic abuse cases. During this time the author completed a joint review of a serious sexual offender with Her Majesty’s Prison Service. The author additionally contributed to a complex serious case review on child sexual exploitation. The author has completed serious further offence reviews and completed IMR training.

The author had also been employed as the Practice Manager for the Safeguarding Children Board, overseeing and managing the serious case review process.

The author had undertaken Home Office training on writing Domestic Homicide Reviews.

1. **AUTHOR OF THE EXECUTIVE SUMMARY**

Following the completion of the Overview Report the Alexandra Stuckey left the post of Partnership Lead Manager and the employment of Torbay Council. Due to the COVID-19 Pandemic there was a delay in recruiting into the post of Partnership Lead Manager by Torbay Council.

In October 2021 Victoria McGeough was appointed to the post of Partnership Lead Manager and took on the responsibility of completing the Executive Summary.

The author of the Executive Summary had no knowledge of Anna or Tom prior to taking on the responsibly of writing the summary and did not work in any of the teams identified in the review.

1. **TERMS OF REFERENCE**

The DHR commenced in November 2017. The terms of reference were set by the Core Group, in accordance with national guidance and the initial lines of enquiry arising from the partner agency information collated at referral stage. The Core Group agreed to focus on the following lines of enquiry:

1. What training and development was delivered on Domestic Abuse and Sexual Violence (DASV) by the Community Safety Partnership during the period covered by the review and how accessible was this to members of the community?
2. To review the current opportunities for engagement with minority ethnic groups within the community and to establish to what extent existing engagement focuses on health and welfare issues.
3. To review Anna’s case with the Torbay Domestic Abuse Service to establish the facts of the case as known, and whether, had any disclosure been made, what service might have been offered and any challenges identified.
4. To make contact with Sexual Health Services to discuss their current practice around routine, sensitive enquiry, identify any challenges to this and to identify any further training and developmental needs.
5. To review opportunities to engage with small employers within the local community to raise awareness of DASV and other safeguarding concerns.
6. **BACKGROUND INFORMATION (KEY FACTS)**

In June 2016 Anna was found in the courtyard of her accommodation, with multiple stab wounds to her abdomen, neck and collarbone area. Anna was pronounced dead shortly after her arrival at Torbay hospital.

At the time of Anna’s death, she was living in a privately rented one bedroom flat with Tom. Anna and Tom were reported to have been in a relationship for approximately six months prior to her death.

A post-mortem concluded that Anna had died as a result of her stab wounds and the post-mortem examination found additional injuries which were consistent with a sustained and violent attack, including black eyes, and extensive bruising to her arms, legs and head. It was not clear at what point the additional injuries had been sustained, however it was considered that they had occurred within a short time of her death, not suggestive of prolonged historical abuse.

Tom was found at the side of Anna by the attending emergency services, holding a knife and covered in Anna’s blood. Research of his electronic devices found recent searches into using knives and pens to cause injury and death.

During Police interview following Anna’s death, Tom gave a no comment interview. As stated in section 1 of this report, Tom took his own life whilst on remand awaiting trial for Anna’s murder. Whilst Tom was never convicted for Anna’s murder, the balance of evidence in this case would suggest that Tom was responsible for killing Anna. The police investigation was concluded as ‘detected’ following Tom’s death.

1. **CHRONOLGY**

Anna moved to the UK in 2014 from Poland and Tom had moved to the UK from Grenada in 2011, being granted Extended Leave until August 2016.

In 2009 Tom was visiting his grandmother in Paignton and contact was made with Torbay Children’s Social Care as Tom’s mother, who was residing in London, had threatened to come and take him to London with her. The grandmother was advised to seek legal advice and no further action was taken. There was no further contact when Tom relocated to the UK in 2011.

Anna and Tom met whilst both were working in a local shop during 2015, and Anna moved to work in another local shop in October 2015. Anna and Tom’s relationship was reported to have commenced sometime between October 2015 and January 2016, when they moved into their privately rented flat together.

Both Anna and Tom attended Torbay Sexual Health service in May 2016. Anna and Tom had separate appointments. In each of their appointments, routine screening questions were undertaken, these questions included questions in relation to domestic abuse. Both Anna and Tom replied no to this section. This is viewed as good practice around routine enquiry. Clinical and sensitive inquiry have developed further since this time and this is covered later in this report.

Anna was registered with a General Practitioner and attended routine appointments. Nothing of note was recorded within the case records.

Anna and Tom were observed together on a number of unspecified occasions during their relationship by friends and Anna’s employer. A friend reported that when Anna was out with friends, there “would be a lot of text messages” between Anna and Tom. Sometime during March/April 2016, Anna was out with friends in Torquay. On this specific occasion, her friend recounted Anna receiving a phone call from Tom at which time he stated that he was in Paignton. However, he then appeared less than five minutes later. She recalls thinking at the time that it would have been impossible for him to get to Torquay from Paignton in such a short space of time; a distance of approximately three miles.

Another friend recounted how during this time, Anna had disclosed that “she wasn’t allowed to wear what she wanted to wear” and that she “was only allowed to wear trousers to parties”. She had also disclosed that Tom didn’t like her attending parties without him.

In the weeks prior to her death, Anna had confided in a couple of friends that she intended to end her relationship with Tom, stating “they were not a good match and that she wanted to finish that relationship”. She also stated that she had offered to move out of their shared flat, however hadn’t done so at the time of her death.

Anna had also met another male, Peter, however the nature of this relationship was unclear, as was also whether or not Tom was aware of this relationship.

On the day of her death at approximately 9.30am, Anna contacted her employer to state that she had had an accident and that “her face wasn’t looking good”. She said that she would need at least a week to recover.

At 10.11am, Anna had a text message conversation with her friend, stating that “she did not look presentable, she couldn’t write because he was looking into her phone and that she would call when she “gets out‘’. The last message received by Anna’s friend was at 10.46am.

At 12.11pm Peter contacted the Police saying that he had been in text conversation with his friend, Anna, and that during this exchange she asked for help saying she was trying to get out of her house. He went on to state that her boyfriend wasn’t letting her go and was threatening her with a knife.

At 12.14pm a neighbour contacted Police to say that a female was lying in the courtyard of Anna and Tom’s address covered in blood.

The initial Police Officer in attendance looked over the wall of Anna and Tom’s address and saw a female laid on the floor of the courtyard, with a male 4 to 5 feet away from her in an agitated state.    He entered the courtyard, assessed Anna and attempted to speak with Tom.

A further officer arrived at the scene and together they were able to arrest Tom. Anna was pronounced dead at 1.15pm at Torbay hospital.

1. **CONCLUSIONS**

There is evidence in this case of coercive and controlling behaviours and potentially stalking. Behaviours that have been clearly identified as indicators of risk of serious domestic abuse through research. As stated, Anna also intended to end the relationship, another known risk indicator for serious domestic abuse. Tom’s behaviour leading up to the homicide indicated clear intent and planning, however no signs of escalating risk were visible to those around Anna or Tom.

It is further apparent in Anna’s case that there was very little opportunity to have intervened or acted any differently on agencies’ parts. It could also be surmised that Anna’s own understanding of coercive and controlling and stalking behaviour wasn’t present, and this could explain her lack of disclosures to services and/or friends and family.

Whilst the Serious Crime Act 2015 included the addition of the crime of controlling and coercive behaviour, no work has been completed within Torbay in respect of raising public and practitioner awareness of this behaviour. This would therefore be a priority moving forwards to ensure that behaviour is reported and acted upon appropriately.

There were no clear indicators in Tom’s life that could have been acted on any differently. Statements taken from his employers and friends at the time of Anna’s death did not highlight any concerns about his behaviour or wellbeing.

On the balance of information in this case the panel did not believe, sadly, that Anna’s death was preventable.

1. **LESSONS TO BE LEANRED**

The key elements of learning in this case are around the recognition and response to coercive and controlling behaviour and stalking by victims by the community and professionals and the practice of routine, sensitive and clinical inquiry within agency contact with potential victims around domestic abuse and sexual violence.

The review has also highlighted that particularly within some groups in society, the recognition of coercive and controlling behaviours may be further inhibited by barriers such as culture, access to mainstream services and personal experience and this should be considered within any future campaigns to ensure that these potential barriers are addressed.

1. **RECOMMENDATIONS FROM THE REVIEW**
2. The agencies within Torbay Community Safety Partnership should review, develop, and amend all of their literature, training and resources on DASV to ensure that accessible information on coercive and controlling behaviour and stalking is included.

2) Torbay Community Safety Partnership should consistently implement methods of raising public and practitioner awareness of coercive and controlling behaviours and stalking and the Serious Crime Act 2015. These methods should be kept under review to ensure that they are effective and in line with best practice.

3) Torbay Community Safety Partnership should develop a ‘minimum standard’ for all public facing campaigns that utilises public space and community resources to promote materials and key messages. This could include as examples, places of worship, community centres, entertainment venues, local businesses. Targeted use of social media has also been demonstrated to have a positive impact. Feedback on impact should be sought from communities.

4) Torbay Community Safety Partnership should ensure that any resources that are developed on DASV, are available in a range of languages specific to their local community profile and seek feedback on quality from those communities

5) Torbay Community Safety Partnership should seek assurance that Health organisations are compliant with NICE Guidance PH50 and Quality Standard [QS116] and request this assurance to be fed back to the Community Safety Partnership through the Clinical Commissioning Group.

6) Torbay Community Safety Partnership should continue to build relationships with local business networks to raise awareness of safeguarding concerns and encourage use of campaigns such as White Ribbon and the toolkit developed by Business in the Community and Public Health England.