Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence Crime and Victims Act 2004
Two deaths in Norfolk
July 2016

Report Author: Christine Graham
September 2017

Preface

Norfolk County Community Safety Partnership wishes at the outset to express their deepest sympathy to both families, particularly to their parents and children. This review has been undertaken in order that lessons can be learned from this situation and we appreciate the support and challenge of the families with this process.

The Independent Chair and Report Author would like to thank the staff from statutory and voluntary sector agencies who assisted in compiling this report.

To protect the identity of the victim, the perpetrator, and family members the following pseudonyms have been used throughout this Review:

The victim: Stephanie, aged 48 years at the time of her death.
The perpetrator: Mark, aged 47 years at the time of his death.

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Section One – The Review Process

1.1 Introduction and agencies participating in the Review

This summary outlines the process undertaken by the Norfolk County Community Safety Partnership Domestic Review Panel in reviewing the death of two of its residents. These deaths occurred in July 2016.

In order to protect the identity of victims and their family members, the following pseudonyms have been used:

> Female victim: Stephanie Johnson who was 48 years old at the time of her death
> Male perpetrator: Mark Johnson who was 47 years old at the time of his death

The deceased was a female, aged 48 years, who was killed by her husband, aged 47 years, at their home. He then took his own life.

The couple had been married for 11 years and, other than a shotgun and firearms licence held by Mark, neither were known to agencies.

On the evening of the incident, Mark visited his GP as he was suffering from depression and having trouble sleeping, which he attributed to difficulties in his marriage, and was prescribed a short course of anti-depressants. On returning home after this appointment, the perpetrator placed his shotgun, which he then loaded, under the bed in the bungalow that he shared with Stephanie. The ambulance service alerted the police after they had been called to the property following a report that a man had shot himself. On arrival, the police found Mark deceased in the front garden of the premises. There was a shotgun next to his body. On checking inside the property, Stephanie was found deceased in one of the two lounges.

Norfolk County Community Safety Partnership was notified of the deaths by Norfolk Constabulary on 14th July 2016. On 4th August, the Chair of the Community Safety Partnership chaired a DHR Partnership meeting and the decision was made to undertake a Domestic Homicide Review and the Home Office was notified of the decision on 8th August.

An Independent Chair and Report Author was appointed and the Review Panel met for the first time on 16th December 2016.

The Coroner held the inquest into Stephanie's death on 5th January 2017 and recorded a finding of unlawful killing. The inquest into the death of the perpetrator has been adjourned waiting for the outcome of the Domestic Homicide Review.

As part of the review, an IMR[1] was completed by the police and detailed reports were provided by the GPs of both Stephanie and Mark.

The Panel met 24th August 2017 to discuss the draft report and the findings therein.

It was not possible to complete the review within the six-month timescale set out within the statutory guidance due to the delays and difficulties in engaging with Stephanie's GP.

[1] Independent Management Reviews

The following agencies and individuals contributed to this review:

- Borough Council of King's Lynn and West Norfolk
- GP surgery for perpetrator
- GP surgery for victim
- Leeway Domestic Violence and Abuse Services
- MAPPA Co-ordinator
- National Probation Service
- NHS England Midlands and East (East)
- Norfolk and Waveney Clinical Commissioning Groups
- Norfolk Constabulary
- Norfolk County Council
- Norfolk Safeguarding Adults Board
- Office of Police and Crime Commissioner
- Ormiston Families
- Queen Elizabeth Hospital, King's Lynn
- Mark's children
- Mark's ex-wife
- A neighbour

1.2 The Review Panel Members

The Panel was made up of the following members:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Nicky Hampson	Service Development Manager, Positive Pathways	Ormiston Families
Margaret Hill	Community Services Manager	Leeway Domestic Violence and Abuse Services
	Nurse Practitioner[2]	Stephanie's GP surgery
Gareth Jackson	Senior Probation Officer	National Probation Service
Dawn Jessett	Community Safety Assistant (DHR Administrator)	Norfolk County Council
Penny Levett	Safeguarding Practitioner	Norfolk and Waveney Clinical Commissioning Groups
Andy Nederpel	Anti-Social Behaviour Manager	Borough Council of King's Lynn and West Norfolk

[2] Name redacted to protect the name of the victim

Val Newton	Deputy Director of Nursing	Queen Elizabeth Hospital
Jane Ross	Patient Experience and Quality Lead	NHS England Midlands and East (East)
Jon Shalom	CCSP Business Lead	Norfolk County Council
Julie Wvendth	Detective Superintendent, Safeguarding	Norfolk Constabulary
Walter Lloyd-Smith	Business Lead for Norfolk Safeguarding Adults Board	Norfolk County Council

1.3 Domestic Homicide Review Chair and Overview Report Author

1.3.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary has been employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework. Gary has undertaken three Domestic Homicide Reviews as Overview Report Author or combined Overview Report Author/chair (with five more currently in progress).

1.3.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. Christine also delivers Partnership Healthchecks which provide an independent view of partnership arrangements. Christine is also a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews.

1.3.3 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[3]

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36 page 12), Home Office, December 2016

1.3.4 Both Christine and Gary have:

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports
- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended the AAFDA Annual Conference (March 2017)
- Attended training on the statutory guidance update in 2016
- Undertaken Home Office approved training in April/May 2017

1.4 Purpose and Terms of Reference for the Review

According to the statutory guidance, 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 these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

The Panel agreed that the specific purpose of the Review is to:

- Establish the facts that led to the incident in July 2016 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter-agency responses were appropriate leading up to and at the time of the incident in July 2016; suggesting changes and/or identifying good practice where appropriate.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process

The scope of the review, as agreed by the Panel, is to:

- Seek to establish whether the events in July 2016 could have been reasonably predicted or prevented

- Consider the period from 1st January 2003 to the events in July 2016 subject to any information emerging that prompts a review of any earlier incidents or events that are relevant

- Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review

- Seek the involvement of family, employers, neighbours and friends to provide a robust analysis of the events

- Produce a report that summarises the chronology of the events, including the actions of agencies, analyses and comments on the actions taken, and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature

- Aim to produce the report within the timescale suggested by the Statutory Guidance subject to:
    - guidance from the police on any sub-judice issues,
    - sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other issues emerging

Section Two –
Agency contact and information learnt from the Review

Stephanie and Mark had been married since June 2005, both having children from previous marriages. The initial view of agencies was that there was no evidence of domestic abuse in their marriage, although, conversations with Mark's family painted a picture of long term abuse in his first marriage. Mark's first wife had not sought any support from agencies and left her husband when she could no longer protect the children from witnessing the abuse. Following the separation, Mark continued to make threats to her which were reported to the police on two occasions.

The Panel has reviewed those previous reports, which amounted to verbal intimidation by Mark including threatening to kill her with a shotgun. On both occasions, the victim did not want the police to take any further action. However, the police do appear to have acted appropriately on both occasions with both incidents being recorded, references made to Victim Support and notification to the Firearms Officer of the incidents. The Panel has considered carefully the relevance of these incidents, given the passage of time, and feel that they tend to show that Mark was prepared to use threats and intimidation at a time of great stress, such as the stress he would have felt at the time of this incident. However, detailed scrutiny of these two incidents is not necessary for the purposes of this report.

Mark was, according to his family, a man who liked to have a drink and would have periods of binge drinking, followed by times of abstinence. He was a holder of a shotgun and firearm certificate.

Towards the end of December 2015, Stephanie became unhappy in her marriage and became friends with a man, known as Witness A. In June 2016, Stephanie and Mark went on holiday. Stephanie was very unhappy when they returned home as Mark had been drunk most of the time. She began to spend more time with Witness A. Stephanie told Mark that she loved him, but was not *in love* with him. Mark suspected that she was having an affair and the situation came to a head the evening of the incident when he had been looking at Stephanie's emails and found some from a dating website. Mark was distressed and had broken down and been physically sick.

When Stephanie arrived home, they went together to Mark's GP (although Mark went into the consultation alone). The GP talked to him about how he was feeling and he was prescribed a short course of anti-depressants.

From the extensive CCTV inside the home, we can see the movements of that evening, although there is no sound to allow us to hear the conversations. We can clearly observe Mark bringing the shotgun into the bedroom and putting it under the bed. He then brings the ammunition and loads the gun, placing it back under the bed. This process took approximately 20 minutes and took place from 18.19 hrs, some six hours before the shooting takes place.

We can see that there was a lot of discussion between Stephanie and Mark and, from evidence available to the review, we know that they spent a good amount of time conversing, by text, with friends and family during the evening. At 23.43 hrs Mark sent a final text to one of his children. It said, 'look after yourself and my grandchildren and my mum love you always dad xxxxxxxxxxxxxxxxxxxxxxxxxxx'. This text message was not received. At 23.49 hrs, Mark is seen on the CCTV looking very upset, with his head in his hands and he remains like this until 23.55 hrs. At 23.57 hrs, Stephanie is clearly upset sitting with her head in her hands. A few minutes later Mark

fatally shoots Stephanie and leaves the property carrying the shotgun. When the police arrived, they found Mark dead in the front garden.

During the ten years of their marriage, Stephanie and Mark had no contact with agencies.

An Independent Management Review (IMR) was produced by Norfolk Constabulary and both GPs provided a detailed report for the review.

Section Three –
Key issues arising from the Review

History of domestic abuse
The Review Chair and Report Author completely understand that Stephanie's family did not want to be part of the review. This has, however, led to a blank page when it comes to understanding her relationship with Mark and assumptions have had to be made. The Review has, therefore, drawn on the experiences of Mark's first wife and the research that exists to paint a picture of the relationship between Stephanie and Mark. Taken together, this leads the review to suggest that it is likely that there was abuse and coercion in the relationship between victim and perpetrator and that, when we view the research about domestic homicides, Mark displayed enough characteristics to say that the offence could have been predicted.

That said, the review has concluded that the incident could not have been prevented. Stephanie and Mark had little or no contact with agencies during their marriage and therefore the only opportunity to identify the outcome might, arguably, have come from the GP and this is discussed in more detail below.

GP involvement
The Review found that the GP had talked with Mark in detail about his mental state and asked him if he had thoughts of harming himself. Looking back on the consultation, the GP practice has now expanded the question that they ask in these circumstances to, 'do you have any thoughts of harming yourself or someone else?' While this is an example of learning from the incident, the review did not feel that the GP could have done anything further to foresee the actions that would follow that evening.

Pre-meditation
One of the questions that was crucial to the review was whether Mark 'snapped'. The evidence available suggests that this was, at least to some extent, a pre-meditated act. Mark clearly placed the loaded shotgun in the bedroom some six hours before the incident took place.

Should Mark have had access to a shotgun?
Much of the review has focused on seeking to answer this question as it is pertinent to the circumstances and is of importance to Mark's family. The review has established that, in the past, Mark had made threats to kill his first wife with a shotgun and that this had been reported to the police.

The Review spent some time looking at the national guidelines and policies for the issue of shotgun and firearms licences in order to understand whether Norfolk Constabulary had acted appropriately in relation to Mark's licence. It was clear to the review that concerns were raised about Mark's suitability to possess a gun in April 2003 with the Firearms Enquiry Officer agreeing to take control of the gun during the period of marital breakdown. This voluntary relinquishing of the gun was formalised in August 2003 after Mark had been arrested. To this point, the review is satisfied that the police acted in a proportionate and appropriate manner.

Mark then reapplied for his licence in December 2005 and at this point a report was prepared supporting the application. In their review of practices for this DHR the police have identified that while this report included most of the relevant incidents it did not, crucially, include the incident on 27th April 2004 when Mark made threats to his first wife to 'blow her head off'. It is acknowledged by

the police that, if this had been known by the officer considering the application, it would have had considerable bearing on the re-issue of the certificate and may well have led to the application being refused.

The Review was assured that ability to search across all police systems is now more sophisticated and that, if the application were made today, a threat to kill two years earlier would have been identified and would have resulted in the application being refused. That said, given that from 2005 to the incident in 2016 Mark did not come to the attention of the police and therefore it is not unreasonable that he was, during this time, in possession of a firearm.

The Review has sought, in its deliberations about the shotgun, to be cognisant of the prevalence of shotguns and firearms in a rural community in Norfolk, with many people having a licence for shooting vermin and game.

Norfolk's approach to tackling domestic abuse

The review found that Mark's first wife had experienced domestic abuse for a number of years and did not seek help. It would be very easy to be critical of the approach taken to publicise the services available but we must remember that this was in the early 1990s and the approach taken was very different. We cannot be certain that Stephanie experienced domestic abuse, although the evidence and research suggests that this is more likely than not, and we know that she did not seek support from local agencies.

We can see that Norfolk has undoubtedly learned from previous DHRs and has made significant financial commitment to this area. The partners are planning to raise awareness among the wider community such as hairdressers, and this will improve the awareness of the public to the services available.

Section Four – Conclusions

This was a very sad case of a woman killed by her husband. Our thoughts are with the surviving families.

The Review concludes that, on the balance of probabilities, Mark was a man with a history of domestic abuse and controlling behaviour. With hindsight, it might be said that the tragic incidents could have been predicted but, given that neither were engaged with any services, it is hard to see how the events could have been prevented.

Whilst acknowledging that Mark displayed a number of the warning signs for domestic homicide, and one of the biggest triggers occurred in Stephanie's intention to leave, it is felt that this situation may been prevented had Mark not had such easy access to a shotgun.

The Review is satisfied that, at the present time, Norfolk is making great efforts to provide support for victims of domestic abuse through a range of different avenues and that, in the future, it is hoped that there will be more Domestic Abuse Champions in the general population (such as hairdressers) who are in a unique position to identify potential victims of domestic abuse who may not otherwise come to notice.

While the Review wholeheartedly supports the choice of Stephanie's family not to engage in the review and understands their reasons for this, it is very clear that this has resulted in a somewhat 'one-sided' view and that assumptions have had to be made about Stephanie. This has been done as sensitively as possible drawing on research to support the assumptions made.

During the course of this Review, a significant amount of time has been spent with Mark's surviving children who are young adults, some with their own small children. What has been very clear is that they have been deeply affected by this tragic situation and continue to deal with the consequences. It is very disappointing that the level of support afforded, by the Government, to children of the victim, is not available to the perpetrator's children.

Section Five –
Lessons Learned and Recommendations

In line with Norfolk's thematic learning framework, which has been drawn from a number of reviews – Domestic Homicide Reviews, Safeguarding Adults Reviews and Serious Case Reviews – the recommendations will be grouped under the following headings:

- Professional Curiosity
- Information Sharing and Fora for Discussion
- Collaborative Working, Decision Making and Planning
- Ownership, Accountability and Management Grip

An additional section has been added for the purpose of this review – National Recommendations

Professional Curiosity

Lessons Learned
The Review concludes that it is difficult to see what more the perpetrator's GP could have reasonably done in this case. He asked questions of the perpetrator in order that he could gauge, based on the answers given, if he was in need of an urgent referral to Mental Health Services and quite reasonably concluded that this was not needed. The Review noted that Norfolk is working to extend the network of DA Champions to universal services in health and education. This would enable GP surgeries to identify staff who can train as their organisation's DA Champion, supporting colleagues to recognise and understand the dynamics of DA, identifying where this may be an issue through sensitive routine enquiry, making referrals to police specialist agencies as appropriate, and providing further guidance and safety planning to their patients.

Recommendation
That GP practices across the county consider having Domestic Abuse Champions in their surgery.

Lessons Learned
The Individual Management Review undertaken by the hospital indicates that there were no interactions with the hospital that would have been identified as being directly as a result of domestic abuse (e.g. broken bones) and does not indicate that there were any conversations, particularly with the victim, that might have led to a disclosure of domestic abuse. The Review notes the work being undertaken in Norfolk to train Domestic Abuse Champions within a range of settings with a particular focus on health and the fact that the hospital is looking to engage with the programme in all areas not just Accident and Emergency and maternity.

Recommendation
That all hospitals in Norfolk consider having Domestic Abuse Champions in all of their departments.

Information Sharing and Fora for Discussion
No specific recommendations

Collaborative Working, Decision Making and Planning
No specific recommendations

Ownership, Accountability and Management Grip
No specific recommendations

National Recommendations

Lessons Learned
Much time has been lost in this review due to the difficulty in engaging with Stephanie's GP.

Recommendation
It is recommended that, despite the strengthening of the latest statutory guidance more work needs to be done to ensure the co-operation of GPs with Domestic Homicide Reviews. As the problem in this case appears to have been, in part, the payment to be made for engagement, it is recommended that either an agreement is reached about payment for these reviews or it is included in the existing contracts.

Lessons Learned
During the course of this Review, a significant amount of time has been spent with Mark's surviving children who are young adults, some with their own small children. What has been very clear is that they have been deeply affected by this tragic situation and continue to deal with the consequences of this. It is very disappointing that the level of support afforded, by the Government, to children of the victim, is not available to the perpetrator's children.

Recommendation
That the government reviews its policy with regard to support for children affected by domestic homicide and affords the same level of support to children of perpetrators that is available to children of victims.