Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Diana
in November 2018

Report Author: Christine Graham
October 2022

Preface

The Keeping Bristol Safe Partnership wishes at the outset to express their deepest sympathy to Diana's family and friends. This review has been undertaken in order that lessons can learned from her murder; we appreciate the support, the input and the challenge from her family and friends throughout the process.

This review has been carried out in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances culminating in this murder in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by the Keeping Bristol Safe Partnership on receiving notification of the death of Diana in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Diana

On a baking hot day in July 1985 our baby daughter arrived in the early hours of the morning weighing in at just over 8lbs.

The first moment we set our eyes on our little girl we both felt so proud and full of joy. We knew our lives would never be the same. We knew we were blessed and our lives now had a different meaning.

We could see she was going to be happy and energetic with a glint of mischief about her.

As she grew her smiles would melt our hearts. She was always chatty, helping anyone she came into contact with. Everyone loved her and her warm smile which was very comforting. She would light up any room she walked into.

Diana was a bubbly, very sociable girl who loved parties with family and friends.

She was strong willed and an independent young woman.

When she left school at 16 years old she got a job she loved at a local hotel.

Our daughter grew up to be a beautiful person. She was strong, caring and loyal beyond her years. She was so very loving and caring, willing to help anyone who needed her.

When she smiled and laughed it would always melt our hearts.

We never in all our lives thought that she would be gone forever and leave such a big gap in all our lives – and we would have to adjust to losing her. We miss her every day and realise now just how precious life is.

Losing Diana is every parent's worst nightmare – especially the violent and needless way she died.

We cannot put into words how we all feel about losing her – the emptiness, sadness and knowing that we will never see her again is with us every day. We will never come to terms with losing her in such a horrible and needless way and we would do anything to have her back safe with us.

Diana's parents and sister.

Contents

Preface		2
Family Tribute		3
1.1	The Review Process	5
1.2	Contributors to the Review	5
1.3	Review Panel Members	6
1.4	Independent Chair and Author	7
1.5	Terms of Reference	7
2	Summary Chronology	8
3	Key issues arising from the review	10
4	Conclusions	11
5	Lessons identified	11
6	Recommendations	12

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by the Keeping Bristol Safe Partnership (the statutory Community Safety Partnership) Domestic Homicide Review Panel in reviewing the murder of 'Diana' who was a resident in their area.

1.1.2 The following pseudonyms have been used in this review to protect the victim's identity and the identity of her family:

The victim will be known as 'Diana'
The perpetrator will be known as 'the perpetrator'
The couple's children will be known as Child A and Child B.

1.1.3 Diana was discovered deceased in the home she shared with her husband, the perpetrator in this case, in November 2018. A murder investigation was launched, and the perpetrator was subsequently arrested and charged with her murder. The perpetrator pleaded guilty to Diana's murder in May 2019. He was sentenced to life imprisonment with a minimum term to serve of twelve and a half years before he could begin to apply for parole.

1.1.4 This review process began when the police notified the CSP of the circumstances of the case. A multi-agency advisory panel meeting met on 20th December 2018 and reviewed the case. The Chair of the Keeping Bristol Safe Partnership was advised that the initial decision was made not to undertake a Domestic Homicide Review as it was felt that learning from this case may be very similar to another, recently undertaken.

1.1.5 The Home Office were informed of this decision and asked the partnership to review their considerations. The Chair of the Keeping Bristol Safe Partnership reviewed the decision and Home Office were informed on 22nd May 2019 that a review was to be undertaken.

1.1.6 The Independent Chair and Overview Author were appointed in June 2019 and the first panel meeting was held in September 2019. Prior to the initial panel meeting all agencies that potentially had contact with the family were asked to trawl their records for relevant involvement. All records were preserved.

1.2 Contributors to the review

1.2.1 The following agencies contributed to the review by way of IMR.

- Avon and Somerset Police
- Bristol Community Health
- Children' School (completed by Bristol City Council Education Team)
- Children's Centre (completed by Bristol City Council Education Team)
- GP of both Diana and the perpetrator

In addition, the review is grateful to the family court for allowing a review of the information held by themselves.

1.2.2 The review was also assisted greatly by the involvement of the victim's family.

1.2.3 Additional interviews were held with two of Diana's friends and the landlord of the premises in which the couple lived.

1.2.4 The perpetrator was interviewed by the Chair and Author of this review in the presence of an offender manager, in prison, after sentence.

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Samuel Williams	Major and Statutory Crime Review Team & Deputy Authorising Officer	Avon and Somerset Police
Katy Burton	Safeguarding and Quality Manager	BN Clinical Commissioning Group
Verity Fellas	Safeguarding and Quality Manager	Bristol City Council – Children's Services
Henry Chan	Safeguarding in Education Team Manager	Bristol City Council – Safety in Education
Helen Macdonald	Schools Safeguarding Advisor	Bristol City Council – Education
Sophie Prosser	Principal Public Health Specialist	Bristol City Council – Public Health
Anne Fry	Named Nurse for Safeguarding Children	Bristol Community Health
Sarah O'Leary	Next Link and Safe Link Service Manager	Next Link

1.3.2 The review process confirmed that members of the panel and IMR authors were independent of direct engagement with Diana and her husband and were the necessary seniority in their organisation.

1.3.3 The DHR Panel met of four occasions, including a meeting with the victim's family. It was not possible to complete the review within six months as it took some time to secure the medical records for Diana and the perpetrator. The initial Covid-19 lockdown delayed the review further. Once the review was shared with Diana's family, further changes were made to the report. This was then considered by the Review Panel before being submitted to the Community Safety Partnership.

1.3.4 There was very little interaction between Diana, the perpetrator, and statutory agencies in their own right. Most of the interaction that was had with statutory agencies was in respect of their two children. Therefore, the review has looked at these interactions as they provide the most useful, if not the only, interactions in which we can seek the trail of domestic abuse.

1.4 Independent Chair and Overview Author

1.4.1 The Independent Chair for this Review was Gary Goose MBE. Gary is a former police officer who rose to the rank of Detective Chief Inspector, his policing career concluded in 2011. During his policing career he was heavily involved in providing support to the families of murder victims. Following the completion of his policing career he worked as Strategic Lead for community safety with associated responsibilities in a local authority, including domestic abuse services and offender management. For the last six years he has undertaken numerous safeguarding reviews within the UK.

1.4.2 The review author was Christine Graham. 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. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews.

1.4.3 Christine and Gary have completed, or are currently engaged upon, a number of domestic homicide reviews across the country in the capacity of Chair and Overview Author. Previous domestic homicide reviews have included a variety of different scenarios including male victims, suicide, murder/suicide, familial domestic homicide, a number which involve mental ill health on the part of the offender and/or victim and reviews involving foreign nationals. In several reviews they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the IOPC, NHS England and Adult Care Reviews.

1.4.4 Neither Christine or Gary are, or have been, employed by or otherwise associated with, and of the agencies involved within this review. Full details of their training can be found in the overview report.

1.5 Terms of Reference

1.5.1 The review set out to:

a) Identify key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim, perpetrator or their children.

b) Consider whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.

d) Review the quality of any risk assessments undertaken by each agency in respect of Diana and their children.

e) Consider whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

f) Consider whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

g) Consider whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

h) Consider whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

i) Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

1.5.2 The full Terms of Reference are in Appendix One of the Overview Report.

2 Summary Chronology

2.1 Diana was 33 years old at the time of her death. She and her husband had been married for 6 years at the time of her murder and were together for 10 months before they married. They had two children together and lived in a rented, first-floor flat.

2.2 This review has sought to identify any trail of abuse that existed within the relationship between the victim and the perpetrator.

2.3 This review and the police murder investigation identified very little interaction between Diana, the perpetrator, and statutory agencies in their own right. Most of the interaction they did have was with statutory agencies in respect of their two children. Therefore, the review has looked at these interactions as they provide the most useful, if not the only, interactions in which we can seek the trail of domestic abuse.

2.4 There were no prior reports to any agency of domestic abuse between the couple.

2.5 The perpetrator had no criminal convictions, other than a caution for an affray which occurred in 2010. It is recorded that he was with a group of other men who got into an argument after being refused entry to a nightclub.

2.6 What has become clear is that Diana had struggled at school and had a learning difficulty that appears to not have been known to the majority of support agencies that she came into contact with in her adult life.

2.7 The couple were involved with the routine round of midwifery and health visiting services during the pregnancy and subsequent birth of their two children between 2012 and 2014. Nothing remarkable was revealed in these visits although it was noted that Diana was overwhelmed after the birth of the second child and was suffering depression. The routine questioning around domestic abuse was not always asked but it was recorded if it had been asked; it was following the birth of the second child, but no concerns were revealed.

2.8 As the children grew Diana struggled with depression, and in particular weight management issues, but there is no evidence that the reasons for this depression was recorded as being

explored with her GP. The continued engagement of health visiting services followed the children into their early nursery placements and conversations were held between health visiting services and the nursery about what they considered a high number of levels of illness with the children. The children's centre followed these concerns through with a briefing to the primary school prior to the children's initial attendance there. Subsequently, their concerns were allayed by the fact that calls for service and illness were not as substantial as they felt Diana had relayed to them. It appears that both Diana and the perpetrator were involved in discussions about ongoing support and no revelations of domestic abuse were made.

2.9 Ongoing concerns about additional support that Diana may need, children's attendance at the children's centre and a specific incident of behaviour by one of the children resulted in a Team Around the Child meeting being held in February 2018. Both parents attended the meeting and were reported as being 'engaged'. The specific behavioural incident related to one of the children grabbing a child around the neck and saying they were going to 'cut them'. This issue was discussed with the parents who were unable to say why it could have happened. The meeting came to the view that the issue was not felt sufficiently serious to warrant further investigation.

2.10 The children continued to be subject of monitoring both by the Children's Centre and the school as attendance continued to be short of ideal but not of a level to cause extreme concern. It is clear that there was significant levels of dialogue between health visitors and others with Diana in particular about the children's attendance. In short, it appears that the couple were keeping the children off school with very minor ailments, and they were being encouraged to increase their attendance levels.

2.11 Throughout all this time the perpetrator had begun to amass significant levels of personal debt and it is clear that his employment was never going to be sufficient to pay off the level of debt that he was accruing. Diana's family are clear that he lived beyond his means placing the family in a perilous position. The debts to the landlord alone were around £3000 and the landlord had begun to consider how they might be paid off, although no formal action had been taken. The financial concern was never disclosed to agencies who were providing support to Diana. By contrast to the perpetrator, Diana's personal debts were minimal and amounted to things such as overuse of a mobile phone.

2.12 The review has been told that the perpetrator had left his employment as a bus driver following allegation of money going missing, but that he left before disciplinary action was taken. The review has also been told that he encouraged Diana to make a claim against a previous employer for an injury she sustained at work. The review is aware that that claim was refused and that the couple had been notified of this in the days before her murder.

2.13 The perpetrator has not said why he killed Diana. The couple's children had gone to school as normal on the day of the murder, and in fact the couple had been to a school assembly that morning before going shopping and returning home. It was only when neither attended school to collect the children that the alarm was raised.

2.14 Later that evening, the police attended the address that Diana shared with her husband and children, and with the assistance of the landlord, gained access to the flat in which the family lived. On entering the flat, the police found a note propped up on the stairs which read *'Please don't let the little ones in the front room. 'No more suffering, I'm sorry, got pushed to [sic] far this time. Daddy loves you xxx'*

2.15 The perpetrator was arrested later that same night on the M6 in Cumbria having made off from a petrol station without paying and driving dangerously when police attempted to stop him.

2.16 He gave no explanation to the police for his actions in relation to Diana's murder. He gave no explanation to the court at the time of his guilty plea.

3 Key issues arising from this review.

3.1 A Domestic Homicide Review is charged with identifying any trail of abuse that existed in a relationship and what can be learned from each case.

3.2 In this case, the evidence that exists to support that abuse is not clear-cut however, given what ultimately occurred and the information that exists it is reasonable to conclude that this was an abusive relationship, over many years, from the perpetrator towards Diana. That he used a variety of forms of controlling and coercive behaviour to abuse her, preying on her vulnerabilities, her insecurities, and her anxieties.

3.3 He told this review that he was the victim of her abuse. There is no evidence that supports that view other than his words, spoken after the event and after sentence. It is pertinent to note that he gave that explanation neither to the police or to court as part of his defence or indeed mitigation.

3.4 This review has looked closely at whether more could or should have been done to identify the abuse that may have existed in this case. In particular, whether there could or should have been greater professional curiosity as to the cause of Diana's anxiety, the children's attendance and the incident involving Child B's behaviour.

3.5 In addition, the review has been made latterly aware of two occasions in 2012 when Diana sought medical help for injuries to her shoulder, back and head when she reportedly fell down the stairs at home. We have looked at whether there should have been further professional curiosity into these issues.

3.6 It is clear that staff from various agencies were concerned, primarily for the children, and that they did discuss the issues between them, culminating in a team around the child meeting. We have looked at whether domestic abuse was considered as a potential cause of the issues and are assured that it was, although there is no definitive record of it being considered.

3.7 We have looked at the work that is being done already in the area to address these issues and feel that had this not been the case that many more recommendations would result from this review.

3.8 We have looked specifically as to why Diana may not have felt able to talk to any of those support agencies about abuse and how best to reach people such as Diana to inform them of what support is available.

4 Conclusions

4.1 Diana was a young woman who loved her children and was devoted to her family, spending a lot of time with her parents and sister. Diana loved people, she wanted to help those who needed it and wanted to be a good friend and enjoy close friendships. Despite potentially finding social interaction difficult, she persevered and worked hard, perhaps some would say, too hard at being a good friend.

4.2 When sentencing in this case, the Judge commented that domestic violence had not been a feature 'even in a single incident that may be considered as an aggravating feature'. Whilst we cannot be certain, this review has provided evidence that it is likely that the perpetrator had been abusive to Diana for all their relationship. We do not know what she endured at his hands, both physically, mentally, and emotionally but she continued to be there for her children. The struggles that she had with verbal communication may have made it difficult to interpret and understand information given to her. But, as one professional has said, one thing that has always remained consistent is the clear loving relationship that her children enjoyed with Diana.

4.3 Again, we cannot be certain, but it is possible that, despite the years of abuse and the struggles that Diana may have socially, she had found the strength to break away from the perpetrator and the amount of strength that this took cannot be underestimated.

4.4 It is with great sadness that we see that she was not able to follow this through and the review extends its deepest sympathies to Diana's family and friends.

5 Lessons to be learned

5.1 **Bristol Community Health**

5.1.1 There was a need for health visitors to be reminded about asking the question about domestic abuse or 'how are things at home' and that, importantly, it is recorded on the electronic records when this has been done or, when it has not been, why this was. This has been superseded by the introduction of electronic records, which has a prompt for a discussion about domestic abuse as a mandatory field. The action, whether the question was asked or not, and any response, is recorded and if not asked an electronic prompt appears for the next contact.

5.2 **Keeping Bristol Safe Partnership**

5.2.1 That there is a need to continually review the access that local residents have to information about how to report domestic abuse and ensure that this accessible to both men and women. That social media is integral to that approach.

6 Recommendations

6.1 **Department of Health**

6.1.1 That the Department of Health provide guidance to the Home Office to inform DHR Chairs how previous GP records can be accessed.

6.2 **Keeping Bristol Safe Partnership**

6.2.1 That the Keeping Bristol Safe Partnership reviews the research undertaken by this neighbouring CSP and looks to use the findings to inform future strategy, policy, and practice in Bristol.

6.2.2 That when developing communication strategies in respect of the availability of domestic abuse services, methods of contact and information about the various forms of abuse, that all types of social media platforms are considered as integral to that messaging.