SAFER STOCKPORT PARTNERSHIP DOMESTIC HOMICIDE REVIEW IN THE CASE OF LORNA

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EXECUTIVE SUMMARY

1. Introduction

1.1 Key People

Pseudonym	Relationship	Address
Lorna	Female victim	Address 1
Alan	Husband of Lorna (Perpetrator)	Address 1
Child 1	Child of Lorna and Alan	Address 1

1.2 Events Leading to the DHR

On a morning in January 2015 Lorna failed to arrive at work and no contact had been made to explain the absence. This was out of character and a colleague of Lorna became concerned. The work colleague made a number of attempts to contact Lorna without success before contacting a mutual friend who went out to Address 1 where Lorna and Alan lived with Child 1.

It was noted by the friend that both of the couple's cars were on the driveway. Friend 1 knocked at the door, however despite being there for some time, they did not get a reply.

Child 1 had been taken to school as usual by Alan that morning in accordance with their usual routine. Concerns were heightened when Alan failed to collect Child 1 from school that afternoon.

Members of the extended family were notified by school and they contacted a different family friend (a serving police officer) referred to as Friend 2 in this report, who went to Address 1 to establish why no-one had collected Child 1.

According to a police statement given as part of the investigation, Friend 2 looked around the downstairs hall and saw a shadow upstairs. After receiving no reply and having increased concerns Friend 2 forced entry and entered Address 1.

On climbing the stairs Friend 2 found Alan hanging from a rope secured to a beam in the loft. He appeared to have been dead for some time. Friend 2 then went downstairs and into the kitchen and saw Lorna on the kitchen floor. She had severe visible injuries and appeared to have been violently attacked, she appeared lifeless.

Friend 2 telephoned police to report what he had found. Two police officers were dispatched and on arrival they continued the search of Address 1 after the property had been entered by an off duty police officer. Police telephoned the ambulance service who arrived at the scene and pronounced both Lorna and Alan dead. The house was sealed as a potential crime scene and a homicide/coronial investigation was commenced.

1.3 Background to Lorna and Alan

Lorna and Alan were married and had a child, referred to as Child 1 in this report (NB to protect the identity of the Child all references to them will be non-gender specific and Child 1's age will not be referred to).

Lorna had a successful career in a public facing role in a large public sector organisation where she had worked for 7 years. When Child 1 was born Alan gave up his career to stay at home and care for them. Lorna continued in her job and it appears that her income supported the family, although Alan had been successful in an entrepreneurial capacity and the couple appeared to be financially comfortable.

The couple socialised with a small group of close mutual friends who knew them well. Friends described them as a close family.

Lorna and Alan had begun to experience some difficulties in their relationship in the recent past. Lorna had confided in a friend that she was becoming disillusioned with the relationship and that she was considering asking Alan to leave the family home. It is not known whether this had been discussed between them. Alan had also confided in a friend that life was not good. It appears that other mutual friends, work colleagues and possibly family members were unaware of these difficulties as the couple were described in some statements made to the police as being happily married and a 'model' family.

It was known by some of the couples' friends that Lorna had had a relationship with Friend 2 in the past. There is no information suggesting that Alan had discussed this with friends or family or whether this was a cause of difficulty in the couple's relationship. However, there is evidence from the police investigation that Alan had intercepted emails from Lorna's computer [1]and may have also had access to text messages of an intimate nature with a work colleague.

1.4 Police Investigation

A police investigation commenced following the discovery of Lorna and Alan. Alan had left a note indicating that he had killed Lorna and that he immediately regretted his actions. He then hanged himself.

As part of the murder investigation police took statements from family and friends, all of which have been viewed by the Chair of the DHR. Extracts from some of these statements are referred to in this report where considered relevant.

[1] https://www.staysafeonline.org.uk

1.5 Coronial Matters

An inquest into the deaths of Lorna and Alan was held on 23rd June 2015. The Coroner recorded the following verdicts; that Lorna had died of multiple injuries inflicted by Alan; that Alan had died of asphyxiation and had taken his own life.

The Coroner has issued a Section 28 letter to Greater Manchester Police asking them to conduct an internal enquiry into the circumstances at the scene of the homicide, where an off duty serving police officer entered Address 1 prior to officers being called to the scene. This officer was known to be a friend of Lorna and had had an intimate relationship with her in the past.

The DHR Chair and a senior officer from the CSP met with the Coroner following inquest to ensure that all relevant information had been received and to discuss the outcome of the inquest.

1.6 Time Period Under Review

Following initial responses from agencies the time period under review was agreed as January 2013 to January 2015.

2. CONDUCT OF THE REVIEW

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set in the guidance.

Following the publication of the Home Office Action Plan in March 2012 (particularly Action 74, which gave a commitment to "review the effectiveness of the statutory guidance on Domestic Homicide Review"), guidance on the conduct and completion of DHRs has been updated.

The Safer Stockport Partnership (CSP) has commissioned this Domestic Homicide Review. The Review has been completed in accordance with the regulations set out by the Act, referred to above, and with the revised guidance issued by the Home Office to support the implementation of the Act. The Home Office definition of domestic abuse and homicide is employed in this case and this definition is attached to this report at Appendix 1.

The Chair of the Panel wishes to express her personal appreciation to the colleagues who have contributed to the completion of this DHR.

2.1 Terms of Reference and key lines of enquiry

The over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which 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; and

- Prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

- Establish all relevant information / learning from the homicide investigation and the Coroner's Inquest; and

- Ensure as far as possible the involvement of the victim and perpetrator's family/friends and employers.

The Panel has noted that scope of this DHR is limited by the lack of contact by Lorna and Alan with agencies. Information about the relationship between Lorna and Alan has been drawn from statements made by family and friends during the police investigation. Some of the information contained in the statements, which was also discussed at the Coroner's inquest, is of a sensitive and personal nature and could impact the wellbeing of Child 1 in the future. This information will therefore be redacted from this report prior to publication to safeguard Child 1.

2.3 The DHR Panel

Following the notification of the death of Lorna the Safer Stockport Partnership contacted Home Office and agreed to undertake a Domestic Homicide Review.

A DHR Review Panel was established by the CSP and met on three occasions to oversee the process. The Panel received reports from agencies and dealt with any associated matters such as family engagement, media management and liaison with the Coroner's Office.

The Community Safety Partnership appointed an independent Chair/Author to oversee and direct the Review and to write the overview report. The Chair/Author has extensive experience in the field of public protection and community safety and significant experience in conducting Domestic Homicide Reviews and Serious Case Reviews. The Chair had no contact with the victim or perpetrator in this case and had

no professional or personal contact with any of the agencies involved in the Review prior to the incident occurring.

In line with statutory guidance a panel of officers was appointed to conduct the Review. Panel members were selected based on their seniority within relevant agencies and ability to direct resources to the review and to oversee implementation of review findings.

A third sector agency with specific knowledge and experience in relation to domestic abuse was invited to serve on the Panel, as set out below.

Designation	**Agency**
Chair of the Panel	An independent consultant with experience of chairing senior multi-agency working groups, public protection proceedings and community safety and conducting Domestic Homicide Reviews. Has no connection with any agency in the commissioning area or with anyone else involved in the case.
Detective Inspector	Greater Manchester Police
Designated Nurse Safeguarding NHS	Stockport Clinical Commissioning Group
Chief Officer	Stockport Without Abuse (Voluntary Sector)
Community Safety Officer	Stockport Metropolitan Borough Council
Head of Community Safety	Stockport Metropolitan Borough Council
Suicide Prevention Lead	Public Health
In Attendance	
Community Safety Officer – Providing Business Support	Stockport Metropolitan Borough Council

The panel consulted with a Social Worker from Stockport MBC Children's Services Department regarding the safeguarding of Child 1. The Chair and Lead Officer also met with the Coroner following the inquest.

There were no conflicts of interest recorded during the Review. Authors of Individual Management Reviews and short reports were not directly connected to the parties and did not sit on the Review Panel.

2.5 Sources of Information

An initial scoping of agency involvement took place following notification of the death. 22 agencies were contacted to establish whether they had had contact with Lorna, Alan or Child 1. Other than routine contacts with health agencies and education, it was apparent that no member of the family had had contact with any other agency.

Following the appointment of the Chair/Author it was agreed that both Lorna and Alan's employers would be contacted to establish whether anything in their employment records indicated that domestic abuse may have been taking place within the relationship.

The families of Lorna and Alan were contacted to inform them that the review was taking place and to invite their contributions. Contact was made via a specialist Domestic Homicide case worker at Victim Support and through the police Family Liaison Officer. The family were encouraged to contribute to the review, however they did not accept the offer to become involved, and the panel respected their views.

Lorna's mother subsequently asked to read a copy of the draft report and requested that a copy of the final report be made available to her prior to publication.

Information was sought from Children's Social Care in relation to the safeguarding arrangements for Child 1. As these arrangements cover the period after the deaths of Child 1's parents these details are not included in this report. However, the Panel was satisfied that Child 1's safeguarding needs were being met.

The panel liaised with Children's Social Care in relation to ensuring that Child 1 receives specific support from relevant agencies to assist them in dealing with the traumatic events they have experienced.

As Alan appeared to have ended his life by suicide (this was later confirmed by the Coroner's inquest). The panel Co-opted a member of the local Public Health Team with expertise in relation to suicide and suicide prevention to provide guidance on any relevant links between suicide and homicide.

This information was of interest to the panel but was not considered to have a bearing on the domestic homicide as Alan had not previously self-harmed or attempted suicide. With hindsight it appears that Alan may have experienced known risk factors for suicide[2] which may have impacted his state of mind. However, the panel could find no evidence to suggest that Alan had murdered Lorna because he intended to take his own life.

Authors of management reports were invited to attend a meeting with the panel so that reports could be scrutinised and relevant questions posed to the authors. Amendments and clarifications were made following this meeting.

[2] https://www.gov.uk/government/publications/suicide-prevention-second-annual-report

3. INFORMATION PROVIDED TO THE REVIEW

3.1 Contact with Agencies

The following agencies had contact with Lorna and Alan during the period under review and provided information to the review.

- Greater Manchester Police
- Employer of Lorna
- Employer of Alan
- GP of Lorna and Alan
- Central Manchester Foundation Trust
- North West Ambulance Service
- Stockport NHS Foundation Trust
- School of Child 1

Other than routine contact with medical services and with the school of Child 1 there were no contacts with services that would indicate any form of domestic abuse within the relationship between Lorna and Alan.

Neither Lorna nor Alan had had any contact with police prior to the incident leading to this Domestic Homicide Review.

3.2 Perspective of Lorna and Alan's Family

Lorna's family were invited to participate in the review. Both of Alan's parents are deceased.

Lorna's family were contacted via the Police Family Liaison Officer and by a Homicide Support Worker from Victim Support. The invitation to participate in the review was not acted upon and the panel therefore respected the wishes of the family not to be involved in the review.

The panel reviewed information contained in the detailed statements made by friends of Lorna and Alan and decided that they contained sufficient information to determine that there was no disclosure or indication of domestic abuse in the relationship. Some friends were aware of difficulties in the relationship but were adamant that there was no violence, intimidation, coercion or control in the relationship.

3.3 Responses to the key lines of enquiry

Agencies were asked to address the key lines of enquiry set out at 2.2 above. None of the agencies participating in the review, nor any of the family or friends who provided information/statements to the police investigation had any knowledge or indication of domestic abuse in the relationship.

1. *Services provided to Lorna, Alan and Child 1 were appropriate and fit for purpose.*
2. *None of the agencies responding to the DHR had any knowledge of domestic abuse between Lorna and Alan at any time during the period under review..*
3. *No action was taken by any agency to address domestic abuse as there was no knowledge or evidence of domestic abuse.*
4. *Alan was not identified as a perpetrator of domestic abuse and therefore no actions were identified by agency to respond.*
5. *There was no knowledge or evidence of domestic abuse by any agency or family member (although family members did not contribute to the review they did make statements to police which indicate no concerns).*
6. *None of the agencies participating in the review identified any issues relating to drugs, alcohol or mental health in relation to Lorna or Alan during the period under review. Alan's GP reported an historic concern regarding Alan's levels of alcohol consumption, however, there is no indication that at any time during the period under review there were concerns regarding this.*
7. *There were no specific diversity issues relating to either Lorna or Alan. The victim and perpetrator were both white British.*
8. *There were no issues relating to safeguarding children prior to the deaths of Lorna and Alan. Following the deaths of their parents, appropriate action was taken to safeguard.*
9. *None of the agencies participating in the review identified any capacity or resource issues that impacted their ability to provide services.*
10. *There are no issues of information sharing relating to the case. Lorna and Alan made minimal use of services, where it was necessary for these services to share information this was done so in an appropriate, timely and effective way.*
11. *There were no concerns in relation to Lorna, Alan or Child 1 that warranted risk assessment or escalation of concerns.*

12. *None of the participating agencies require amendment or new procedures or policies/training as a result of this case. Agencies responding have domestic abuse policies, although it was not possible to determine whether Alan's employer has a specific policy.*

No other information was highlighted by any agency involved in the review.

4. LEARNING FROM THE DHR

4.1 Analysis

The DHR panel could find no evidence of physical abuse in the relationship between Lorna and Alan.

The family had little contact with services, other than medical appointments for specific medical conditions that have no relevance to this review. The employers of both Lorna and Alan had no knowledge of domestic abuse or disharmony in the relationship, in particular Lorna's employer observed that she was planning a family holiday and looking forward to it.

Police had had no previous contact with the family prior to the homicide and Child 1's school observed the dedication of both parents and their engagement with the school.

None of the agencies who provided information to the review, nor any of the information gathered by the police during their investigation, including statements from friends and family (who did not wish to participate in the review) reported any indicators of abuse. Some of the behaviours in the relationship could be construed as coercive and controlling however these related to aspects of the couple's lives which the panel judged should not be included in the published report to protect Child 1.

There were indications in the statements made to police by friends that the relationship between Lorna and Alan had become strained over recent years, and both had confided in friends that they were having difficulties however neither ever talked about or reported domestic abuse.

Information gathered during the police investigation suggests that Lorna may have had an intimate relationship with a friend of the family in the past and that Alan had suspicions about the relationship. There were also suggestions that Lorna had shared intimate text messages with a colleague and that Alan had been trying to access messages on Lorna's computer in the days before her death.

These suspicions may have contributed to the relationship difficulties but there is no evidence that either Lorna or Alan were using controlling or coercive behaviour in their relationship.

There is no indication in any of the information received by the Review that there were any issues in relation to financial matters within the relationship. Lorna was employed in a senior management position and Alan appeared to be financially secure following the sale of rights to a product he had developed.

5 CONCLUSIONS AND RECOMMENDATIONS

The review panel offer their condolences to the family and friends of Lorna and Alan.

The panel has concluded that none of the agencies participating in the review, nor the families and friends of Lorna or Alan could have predicted or prevented the homicide or the subsequent suicide of Alan.

Other than indications of relationship difficulties discussed with friends, there were no indications that the relationship between Lorna and Alan contained any form of domestic abuse. There are aspects of the relationship between Lorna and Alan that could be construed as coercive and controlling, however it is not possible for the panel to comment on the nature of specific events as the relationship difficulties between Lorna and Alan are deemed to be of a private nature.

The panel has concluded that there is no specific learning emerging from this case however the CSP will ensure a continued focus on encouraging anyone who may be experiencing domestic abuse to seek advice and support. Stockport CSP has a robust domestic abuse strategy that includes universal and targeted awareness raising and training for professionals.

Agencies participating in the review have demonstrated an acceptable level of awareness in relation to domestic abuse and have domestic abuse polices in place, the Stockport partnership will continue to work with agencies and employers in this regard.

The panel noted that paramedics did not complete the necessary certificate following attendance at the scene of death. The DHR Chair has written to NWAS to ensure that this is noted and acted upon in this and in future cases.

The panel noted that Alan's employer, a national organisation, were difficult to contact in the first instance other than by a general 'enquiries' email address. The Chair of the DHR has written to the organisation suggesting that consideration is given to establishing a point of contact for confidential enquiries[3] related to reviews such as this, to ensure effective communication and the maintenance of confidentiality.

[3] http://www.equalityhumanrights.com/new-guidance-launched-help-employers-support-staff-experiencing-domestic-abuse