Domestic Homicide Review (DHR)

Beth

2018

Executive Summary

Author: Alan Critchley

Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review completed: 24th July 2023

Beth, some words from her mother.

"*Beth was a beautiful woman inside and out, although at times she could be quite headstrong she was a loving mother and cared about her children above all else. Beth would help anyone she knew if they were having problems both practically and even just a shoulder to cry on. Her sense of fun and enjoyment, her humour are the things we miss, she was the person I loved spending time with most and nearly 4 years on its still raw and I cannot come to terms with the fact that I will never see her again, when you say bye, love you good luck with the job interview you don't believe that will be the last time you ever see them.*

Beth was also very clever when she went through the various court hearings to get her children back, she had minimal legal advice she did everything herself, represented herself in court and gradually won her children back by following the judge's direction at every hearing as legal aid was not available and in Beth's words any money I have is for my children to pay a lawyer or barrister is just not affordable. Beth wanted to help other women who found themselves in the same position unable to fight their ex-partners in court due to lack of funds.

Beth was a good friend, a caring sister, a loving mother and a daughter whose death made the world a darker place for all who knew her, her smile could light up a room and if upset a look that could kill at fifty places."

Beth's Mother

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1. The Review Process

Introduction

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Beth, a resident of Kent, prior to her death in October 2018. On that day Beth was known to have arrived home in the evening and was in contact with friends up to 22:00 that night. That was the last time that Beth was heard from.

1.2 This DHR examines the involvement that organisations had with Beth who was white British and in her mid-40s at the time of her death and Richard who was white British/Spanish and in his late 30's, between June 2014 and Beth's death.

1.3 Contributors to the Review

1.4 Each of the following organisations were subject of an IMR:

- Kent Police
- Children and Family Court Advisory and Support Service
- The Education People
- Kent Community Health NHS Foundation Trust
- Kent and Medway Clinical Commissioning Group
- Surrey Clinical Commissioning Group

2. Review Panel Members

2.1. The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Beth or Richard. It also included a senior member of the Kent County Council's (KCC) Community Safety Unit, an independent advisor from a Kent-based domestic abuse service and the KCC Suicide Prevention Programme Manager to provide additional advice and input to the review.

2.2. The members of the panel were:

Agency	Name	Job Title
	Alan Critchley	Independent Chair
KCC Community Safety	Honey-Leigh Topley	Community Safety Officer
Kent Police	Ian Wadey	Detective Chief Inspector
Kent & Medway CCG	Musthafar Oladosu	Designated Nurse for Adult Safeguarding
Surrey Heartlands	Helen Milton	Designated Nurse Safeguarding Adults, Surrey Wide
Note: Since the completion of this DHR, Kent & Medway CCG Surrey CCG has become Kent & Medway Integrated Care Board and Surrey Integrated Care Board.		
KCC Integrated Childrens Service	Kevin Kasaven	Assistant Director Of Safeguarding, Quality Assurance & Professional Standards
KCC, Adult Safeguarding	Catherine Collins	Strategic Safeguarding Manager
CAFCASS	Deborah Bean	Service Manager
Medway NHS Foundation Trust	Bridget Fordham	Head of Safeguarding
Area Council	Maxine Quinton	Community Safety Officer
The Education People	Claire Ray	Head of Service
KCHFT	Andrea Svinurai	Safeguarding Assurance Lead
Choices	Jackie Hyland	Independent Domestic Abuse Specialist

2.3. Members of the panel hold senior positions in their organisations and have not had contact, management or supervisory involvement with Beth or Richard. The panel met on four occasions during the DHR. Later drafts of the report were agreed by panel members via email.

3. Author of the Overview Report

3.1. The Independent Chair, and the Author of this Overview Report, is Alan Critchley.

3.2. He is a safeguarding consultant and is a qualified Social Worker. He has held a number of safeguarding roles, including that of Chair of an Adult and Children Safeguarding Board. As well as writing reviews for Kent, Alan Critchley is Independent Panel Chair for Dimensions UK, an organisation supporting people who have Autism and Learning Disabilities.

3.3. He has completed both modules of the relevant Home Office training and has enhanced knowledge of Domestic Abuse through his work on Safeguarding Partnerships where he held agencies to account for their efficacy with regard to Domestic Abuse.

3.4. The Independent Chair has no connection with the Community Safety Partnership and agencies involved in this review; and currently being commissioned to undertake Domestic Homicide Reviews and Multi-Agency Reviews.

4. Terms of reference for the review

These terms of reference were agreed by the DHR panel following their meeting on 4th November 2020.

4.1. **Background**

4.2. In October 2018 Beth returned home from work. She was in contact with friends via her mobile phone until 10pm but was not heard from again. Richard reported Beth as “missing” some thirty-six hours later, this was done after pressure from Beth’s older sons.

4.3. In spite of exhaustive searches by the police, family and community Beth’s body has not been found.

4.4. Richard was charged with Beth’s murder in December 2018, one of the few perpetrators to be charged in the absence of a body and was found guilty in October 2019. Beth’s body has still not been found.

4.5. Richard was found guilty by unanimous verdict and given a life sentence with the judge commenting, *"it was, I'm sure, a planned and calculated operation that developed as it became clear that Beth's plans were to buy out your stake in the property. If she succeeded in that aim, you risked surrendering control of your family home to her".*

4.6. The Purpose of the DHR

The purpose of this review is to:

- Establish what lessons are to be learned from the domestic homicide of Beth 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 inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for 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 opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

4.7. The Focus of the DHR

- This review will establish whether any agencies have identified possible and/or actual domestic abuse that may have been relevant to the death of Beth.
- If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

- If domestic abuse was identified, this DHR will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. If domestic abuse was identified, the review will examine the method used to identify risk and

the action plan put in place to reduce that risk. This review will also consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

- The full subjects of this review will be the victim, Beth, and the perpetrator, Richard.

4.8. **DHR Methodology**

- The detailed information on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Beth and/or Richard. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.
- Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DHR Panel. Neither the IMR authors nor the Senior Managers had any involvement, management or supervisory, with Beth or Richard during the period covered by the review.
- In addition to IMRs, one organisation provided a Summary Report and documentation about Beth and Richard.

5. Summary Chronology

5.1. Beth and Richard met through internet dating in 2004 and moved to Spain. Their first child, Child A, was born in Spain in 2006. They returned shortly afterwards to the UK and Beth gave birth to twins, Child B and Child C in 2012.

5.2. In 2014 the couple separated with Beth moving out from the family home and, at that time, intending to take the children to live elsewhere in the country. Whilst Beth did have a significant number of moves, she stayed, by and large locally to the family home.

5.3. Over the next four years there were a number of court hearings with regard to contact and residence with the children spending significant amounts of time with both their parents.

5.4. Children's Social Care, the Children and Family Courts Advisory Support Service (Cafcass), Education and the police were all involved with the family at various times. Agency concerns focused on the welfare of the children and any harm to the children from their parents' separation. Whilst the children may well have experienced a degree of harm from the separation, agencies were not looking at Beth's behaviour or demeanour.

5.5. During this period there were occasions where Beth was noted by the agencies in contact with the family as behaving angrily or rather less, apparently, reasonably than Richard.

5.6. Coercive Control and controlling behaviours were not recognised by statute until late in 2015. Recognition and awareness has increased since.

5.7. The accounts of family and friends show that coercive control was a factor in Beth and Richard's relationship almost from the point they met. Throughout the timeline of this review there are numerous examples of occasions where Richard used coercive control on Beth and, probably, other women.

5.8. Some of Beth's reported behaviours towards others can be attributed to her feelings of powerless and loss of control as a victim of abuse. This was not recognised by anyone who knew or worked with her, and no one seems to have questioned why Beth behaved as she did.

5.9. In May 2018 Beth moved back into the family home with Richard. This was a matter of necessity for her, not because they were back together as a couple.

5.10. In September/October 2018 Beth secured new employment and her earnings were such that she was able to take over the mortgage and buy Richard out of the family home.

5.11. In October 2018 Beth was reported as "missing". Her body has not been found. Richard was charged with her murder and was sentenced to life imprisonment.

6. Conclusions

6.1 Beth was subject to domestic abuse from the beginning of her relationship with Richard. This does not appear to have been identified by anyone, either in Beth's family or those professionals who worked with her. In part this is because coercive control was neither an offence nor well known at the beginning of the timeline of this review. In part it is because of a lack of professional curiosity about the way that Beth presented to agencies.

6.2 By the time coercive control was becoming known Beth had been assessed and "labelled" by agencies, notably the schools as "difficult" and the reasons behind her presentation do not appear to have been reassessed or reconsidered in the light of developing information and awareness about coercive control. Coercive Control reached the statute in December 2015 and training was rolled out to agencies after this. Public and professional awareness has also grown in the years since. It would have been possible for anyone working with Beth to have reassessed her presentation in the light of the growing knowledge, but this was not done.

6.3 It is also the case that the separation and concentration on the wellbeing of the children masked the fact that Beth was subject to domestic abuse.

6.4 This, in turn, leads to another potential problem. The schools and Social Care were concerned about the impact of the separation on the children. Children living in/with families where there is domestic abuse require further understanding to limit the harm on them. See, for example https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/domestic-abuse/. In the light of what we now know about domestic abuse in the parental relationship the emotional impact upon the children is likely to have been greater than was known at the time.

7. Lessons to be Learnt

7.1 That coercive control is deep, enduring and dangerous. There are always reasons why people behave as they do. Beth's "*difficult*" presentation was, in all likelihood, linked to her as a victim. It is noteworthy that Beth's response to abuse was multi-faceted and may not, even now coercive control is well known, be

obvious to professionals. Professionals should always question why people behave as they do and not take presentation at face value.

7.2 Professionals should be alert to domestic abuse in all scenarios. In this instance the parental dispute, and the effects on the children masked the coercive control that Beth was subject to. Beth being perceived as "*difficult*" by some agencies compounded this.

7.3 Professionals working with victims of domestic abuse should look at issues through the eyes of the victim.

7.4 This is necessary to ensure that responses are appropriate to individuals and not simply the result of adherence to policy. An appreciation of the level of fear and vulnerability relies on understanding the circumstance of the individual.

8. Recommendations

8.1 The Review Panel makes the following recommendations from this DHR:

	Recommendation	**Organisation**
1.	Coercive control legislation to be integral to the DA Workforce Training programme currently in development in Kent. The concept of controlling behaviour, its form and tactics to also be detailed in this training.	KCC Commissioning CAFCASS
2.	Agencies to promote 'Making Safeguarding Personal' when working with service users and not looking at incidents in isolation; and that the potential for all types of domestic abuse is always explored when parents separate.	All Agencies
3.	All agencies to provide guidance/training for staff regarding 'victim blaming' language, taking into account a trauma informed approach that seeks to understand the root of behaviours / distress and respond to the underlying trauma.	All Agencies

	Recommendation	Organisation
4.	All agencies to provide assurance (via a sample audit) that their staff are compliant with their most recent Domestic Abuse / Safeguarding policies.	All Agencies