Domestic Homicide Review Report

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

Review into the death of Diana
in November 2018

Report Author: Christine Graham
July 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.

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this Review and the process and timescales of the review.

Section 2 of this report will **set out the facts** in this case **including a chronology** to assist the reader in understanding how events unfolded that led to Diana's death.

Section 3 will provide **detailed analysis of the information** of agency involvement.

Section 4 will analyse the **issues** considered by this Review

Section 5 will bring together the **lessons learned** in the Review

Section 6 set out **the recommendations that arise.**

Section 7 will bring together **the conclusions** of the Review Panel.

Appendix One provides the **terms of reference** against which the panel operated

Appendix Two sets out the **questions raised by Diana's family**

Appendix Three sets out the **action plan** to fulfil the recommendations

Appendix Four sets out the **feedback from the Home Office**

Where the review has identified that an opportunity to intervene has been missed, this has been noted in a text box.

Examples of good practice are highlighted in italic type

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Section One – Introduction

1.1 Summary of circumstances leading to the Review

1.1.1 This report of a domestic homicide review examines agency responses and support given to a woman, who will be known for the purposes of this review as 'Diana', a resident of the Keeping Bristol Safe Partnership (the CSP) prior to the point of her murder in November 2018.

1.1.2 In addition to agency involvement the review will also seek to examine the past to identify any relevant background or trail of abuse before her murder, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer for others.

1.1.3 On a weekday evening, at the end of November 2018, police were alerted as the children of Diana and her husband had not been collected from school and contact could not be made with either parent. 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.

1.1.4 On entering the flat, the police found a note propped up on the stairs that, it is now known, was written by the perpetrator, Diana's husband. The note read, *'No more suffering, I'm sorry, got pushed to [sic] far this time. Daddy loves you xxx'.*

1.1.5 They then found Diana deceased in the flat. The perpetrator had fled the scene and police circulated his details to locate him. He was apprehended in the north of England. He was arrested and subsequently charged with Diana's murder. He gave no explanation to police as to what had caused her death. He subsequently pleaded guilty to her murder and was sentenced to a life sentence to serve a minimum of twelve and a half years imprisonment before he was eligible to begin to apply for parole.

1.1.6 The review will consider agency's contact/involvement with Diana, her husband and, where relevant, their children from 2007 onwards as this is believed to have covered the entirety of their relationship.

1.1.7 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and as a thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such cases happening in the future.

1.2 Reasons for conducting the review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case, the victim was the wife of the perpetrator and therefore, the criteria has been met.

1.2.4 The purpose of the 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

1.3 Methodology and timescales for the review

1.3.1 The Keeping Bristol Safe Partnership were notified by the police on 3rd December 2018 of the death.

1.3.2 The 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, DHR.

Diana's family have expressed the view that they feel that this was a poor decision and insulting to their daughter as there must always be learning from the death of a victim.

1.3.3 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.

1.3.4 Gary Goose and Christine Graham were appointed in June 2019 as Independent Chair and Report Author to undertake the review.

1.3.5 Prior to the first panel meeting, officers of Bristol City Council began an initial trawl with local agencies. The Council keeps a list of local agencies whom they contact when they receive

notification of a death that may meet the criteria for a DHR. The names, address and dates of birth of Diana, the perpetrator and their children were shared with a trusted individual within each organisation/ agency and they were asked the following questions:

- Has your organisation had contact with any member of this family?
- If Yes, please state the nature of that contact, noting anything you think may be particularly relevant to the DHR process.

1.3.6 The first panel meeting was held on 10th September 2019. The following agencies were represented at this meeting:

- Avon and Somerset Police
- BN Clinical Commissioning Group
- Bristol City Council – Education
- Bristol City Council – Public Health
- Bristol Community Health
- Next Link (specialist domestic abuse charity)

1.3.7 At this meeting, the process of the Domestic Homicide Review was explained to the Panel with the Chair stressing that the purpose of the review is not to blame agencies or individuals but to look at what lessons could be learned for the future.

1.3.8 At the meeting it was agreed that Bristol City Council, Children's Social Care would be included on the panel, and they attended subsequent meetings.

1.3.9 At this meeting the Terms of Reference were agreed subject to Diana's family being consulted. It was agreed that the scope of the review would be 1st January 2007 to the date of the incident. Any relevant information from outside the timeframe would be included as necessary.

1.3.10 There was very little interaction between Diana, the perpetrator and statutory agencies in their own right. The majority of 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.

1.3.11 As the criminal process was complete the review was able to proceed, and agencies began by compiling a chronology.

1.3.12 Individual Management Reviews were then commissioned from:

- 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

1.3.13 The Independent Chair and Report Author were helpfully made aware, by Diana's family, of reports that had been prepared for the family court hearing. With the assistance of Bristol City Council, Children's Social Care, and the Family Court Judge, these reports were made available to the Chair and Report Author.

1.3.14 The panel met on three further occasions, including a meeting where the family met with the panel, and the review was completed in July 2022. 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 Covid-19 lockdown then 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.

1.3.15 After initial submission to the Home Office QA Panel, the Independent Chair was contacted by the victim's father who said that he had been made aware of additional contact by Diana with her GP and a visit to a hospital that had not been included within the review. Understandably he asked why that was the case. A review of all the information submitted to the review was undertaken and it was clear that these issues had not, at any point, been revealed to the Review. The reasons for this have now been established and this Review is confident that changes made to the process of scoping all organisations, in particular the complex arrangements of different NHS Trusts and bodies across the area, for information will prevent any reoccurrence on other reviews.

1.3.16 That additional information is now included within this review, and we are grateful to the victim's father for alerting us to its existence.

1.4 Confidentiality

1.4.1 The content and findings of this Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2 At the request of her family, the pseudonym, Diana was used for the victim. Pseudonyms have been used for her children:

- Child A for the oldest child
- Child B for the youngest child

1.4.3 The person responsible for Diana's murder will be referred to as the perpetrator or her husband in some parts for readability.

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.

1.6 Dissemination

1.6.1 The following individuals/organisations will receive copies of this report:

- Diana's family
- Bristol City Council
- BNSSG Clinical Commissioning Group
- University Hospitals Bristol NHS Trust
- North Bristol NHS Trust
- NHS England
- Avon and Somerset Police
- Avon and Somerset Police and Crime Commissioner

1.7 Contributors to the review

1.7.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

1.7.2 All Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the panel or meeting for an interview.

1.7.4 The following agencies contributed to the review:

- Avon and Somerset Police
- Bristol City Council – Children's Services
- Bristol City Council – Public Health
- Next Link Housing (specialist domestic abuse charity)
- BN Clinical Commissioning Group
- Bristol Community Health, now transferred to a new provider
- Children's Centre
- Children's School

1.7.5 The perpetrator met with the Independent Chair and Report Author in prison, accompanied by his offender supervisor.

1.8 Engagement with family and friends

1.8.1 The Independent Chair and Report Author wrote to Diana's family at the end of July 2019 introducing themselves and the review. As the family were already being supported by an advocate from AAFDA[1] contact was made, and a time arranged to meet the family.

1.8.2 On 30th September 2019 the Independent Chair and Report Author met with Diana's mother, father and sister at their home. Their AAFDA advocate was present and supported them at this meeting.

1.8.3 The family accepted the invitation to meet the review panel and did this on 11th March 2020. The panel had been briefed, both verbally and with a written guide, by the Independent Chair and Report Author ahead of the meeting.

1.8.4 The Independent Chair and Report Author then met with Diana's family a second time on 14th September 2020. Additional meetings were held on 7th June 2021 and 20th September 2021.

1.8.5 The review was given contact details for friends of Diana and the perpetrator. Two of Diana's friends have contributed to the review.

1.8.6 The perpetrator's family were written to in November 2019. As no replies were received, a further letter was sent in March 2020. No response was received; the review respects their wish to not be involved. Where relevant, information has been drawn from the family court proceedings to reflect their views given in that forum.

1.8.7 Diana's family were provided with a copy of the draft report at the meeting on 7th June 2020. It was left with them to read in their own time, supported by their AAFDA advocate. The family provided feedback, together with additional questions. The report was revised

[1] Advocacy After Fatal Domestic Abuse

accordingly. The Chair and Report Author met with the family on 20th September 2021 to discuss their feedback to the report. Following this meeting, further changes were made to the report that were agreed with the family. At this point the report was presented to the Review Panel for approval for submission to the Community Safety Partnership.

1.9 Review Panel

1.9.1 The members of the Review Panel 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

1.9.2 All 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.

1.10 Domestic Homicide Review Chair and Overview Report Author

1.10.1 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 was 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 as well as substance misuse and housing services. 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.

1.10.2 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. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. 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. Christine chairs her local Safer off the Streets Partnership.

1.10.3 Gary and Christine 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.

1.10.4 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.[2]

1.10.5 Christine has attended:

- AAFDA Information and Networking Event (November 2019)
- Webinar by Dr Jane Monckton-Smith on the Homicide Timeline (June 2020)
- Ensuring the Family Remains Integral to Your Reviews - Review Consulting (June 2020)
- Domestic Abuse: Mental health, Trauma and Selfcare, Standing Together (July 2020)
- Hidden Homicides, Dr Jane Monckton-Smith, AAFDA (November 2020)
- Suicide and domestic abuse, Buckinghamshire DHR Learning Event (December 2020)
- Attended Hearing Hidden Voices: Older victims of domestic abuse, University of Edinburgh (February 2021)
- Domestic Abuse Related Suicide and Best Practice in Suicide DHRs, AAFDA (April 2021)
- Post-separation Abuse, Lundy Bancroft, SUTDA (April 2021)
- Ensuring family and friends are integral to DHRs, AAFDA (May 2021)
- Learning the Lessons: Non-Homicide Domestic Abuse Related Deaths, Standing Together (June 2021)
- Suspicious Deaths and Stalking, Professor Jane Monckton-Smith, Alice Ruggles Trust Lecture (April 2021)
- Reviewing domestic abuse related suicides and unexplained deaths, AAFDA (May 2021)
- Young people and stalking: Reflections and Focus, Dr Rachel Wheatley, Alice Ruggles Trust Lecture (May 2021)
- Giving children a voice in DHRs – AAFDA (November 2021)
- Cross Cultural Training Webinar – Incels and Online Hate – HOPE Training (November 2021)
- Male victims of domestic abuse, Buckinghamshire DHR Learning Event (January 2022)
- Older victims of domestic abuse, Dr Hannah Bows, DHR Network (February 2022)
- Enhancing the cancer workforce response to domestic abuse – Standing Together and Macmillan (April 2022)

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

2.2 Christine has completed Homicide Timeline Online Training (Five Modules) led by Professor Jane Monckton-Smith of University of Gloucester.

2.3 Gary and Christine have:

- Attended training on the statutory guidance update (May 2016)
- Undertaken Home Office approved training (April/May 2017)
- Attended Conference on Coercion and Control (Bristol June 2018)
- Attended AAFDA Learning Event – Bradford (September 2018)
- Attended AAFDA Annual Conference (March 2017,2018 and 2019)
- Attended Mental Health and Domestic Homicides: A Qualitative Analysis, Standing Together (May 2021)
- Attended AAFDA DHR Chair Refresher Training (August 2021)
- Commissioned bespoke training on DHRs and Suicide, Harmless (March 2022)

1.11 Parallel Reviews

1.11.1 The Coroner closed the inquest following the completion of the criminal process.

1.11.2 There are no other reviews.

1.12 Equality and Diversity

1.12.1 Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.12.2 Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[3] Women are more likely than men to be killed by partners/ex-partners. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[4]

1.12.3 **Pregnancy**

1.12.3.1 Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth[5]. 20-30% of pregnant women report incidents of physical

3 (Women's Aid Domestic abuse is a gendered crime, n.d.)
4 (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)
[5] https://www.nhs.uk/pregnancy/support/domestic-abuse-in-pregnancy/

violence during pregnancy. 36% or women experience verbal abuse during pregnancy. 20% of pregnant women are subject to sexual violence and 14% of pregnant women report sever or life-threatening violence[6].

1.12.3.2 Dealing with violence and controlling behaviour can impact on a woman's mental health and wellbeing. Worries about their own safety are compounded by concerns for their baby[7]. Research undertaken by Levesaque at al (2021)[8] noted that parental responsibility in an abusive relationship was described by women as a need for greater vigilance and the need to protect children from violence.

1.12.3.3 Domestic abuse can increase the risk of miscarriage, infection, premature birth, and injury or death to the baby[9]. The risk that a baby will die during pregnancy or birth are between 2-2 ½ times higher when domestic violence occurs[10].

1.12.4 **Mental health**

1.12.4.1 It is known that Diana experienced depression and anxiety.

1.12.4.2 Domestic abuse can have a devastating and long-lasting on the mental health of victims/survivors of domestic abuse and these mental health impacts can be weaponised by perpetrators[11].

1.12.4.3 A literature review undertaken by Women's Aid[12] found that the language used to describe more mental health generally showed very little and usually no understanding of mental illness as a result of trauma and a consequence of domestic abuse.

Section Two – The Facts

2.1 Introduction

2.1.1 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.

2.1.2 A post-mortem established that the cause of Diana's death was ligature strangulation.

2.1.3 Following Diana's death, the Family Court made a decision about guardianship of the children. The review is grateful to the Judge for having provided the papers of this process to the Independent Chair and Report Author. These have been very useful and will be referenced, particularly in the analysis section[13].

[6] https://www.womensaid.org.uk/wp-content/uploads/2019/12/Supporting-women-and-babies-after-domestic-abuse.pdf
[7] Ibid
[8] Qualitative exploration of the influence of domestic violence on motherhood in the perinatal period, Levesque et al, Journal of Family Violence, 2021
[9] https://www.nhs.uk/pregnancy/support/domestic-abuse-in-pregnancy/
[10] Meuleners, L. B., Lee, A. H., Janssen, P. A. & Fraser, M. L. (2011) Maternal and foetal outcomes among pregnant women hospitalised due to interpersonal violence : A population based study in Western Australia, 2002-2008 cited https://www.womensaid.org.uk/wp-content/uploads/2019/12/Supporting-women-and-babies-after-domestic-abuse.pdf
[11] Mental health and domestic abuse, Birchall J and McCarthy L, Women's Aid, 2021
[12] Ibid
[13] It should be noted that these papers have not been made available the full review panel

2.1.4 A chronology of events and a summary of information known by family, friends and agencies will follow within this report.

2.2 Chronology

2.2.1 In June 2010 the perpetrator was amongst a group of males who were refused entry to a nightclub. They then became aggressive, and several punches were thrown. The men were detained until police arrived and they were arrested. The perpetrator was given a caution for affray.

2.2.2 In early 2012 Diana became pregnant with the couple expecting their first child.

2.2.3 On 5th March (a Monday) she contacted her GP saying that she had fallen down the stairs that weekend hurting her shoulder and back, and that she was still in pain. She was prescribed medication for the pain.

2.2.4 On 30th March Diana attended a local hospital emergency department reporting that she had fallen down the stairs the previous night banging her head on the concrete floor. She was examined and discharged with minor head injury advice. The hospital subsequently wrote to Diana's GP informing them of the attendance.

2.2.5 On 13th April it is recorded that Diana's GP tried to contact her by telephone but that there was no answer and no facility to leave a message. The reason for this call is not recorded however, it is reasonable to assume that it was in follow-up to the hospital notification of her attendance.

2.2.6 The police were called when Diana and the perpetrator were awoken in the night during June 2012 by two males who were trying to steal their car. No further action was taken as the car was not stolen.

2.2.7 In December 2012 the health visiting service made their first visit to Diana and the perpetrator following the birth of Child A. It was recorded that domestic abuse was not asked about as relatives were present during the visit.

2.2.8 **2013**

2.2.9 The health visitor visited again in January 2013 to complete the Health Needs Assessment. Enquires about domestic abuse were not made as a relative was present during the visit. The assessment indicated no significant history that could impact on the parenting ability and so the family were to receive a Universal Service[14].

2.2.10 The developmental review for Child A was undertaken in November 2013. Both parents were present so no enquiry about domestic abuse was made.

2.2.11 **2014**

[14] A Universal Services from a health visiting team means working with general practice to ensure that families can access the Healthy Child Programme, and that parents are supported at key times and have access to a range of community services. Currently there are five mandated visits from birth until 3 years

2.2.12 Contact with the health visiting service resumed in May 2014 following the birth of the Child B. Both parents were present at the primary visit and no domestic abuse was disclosed. The perpetrator was noted as appearing supportive and participating in childcare. Diana was signposted to her GP regarding her mood and other child focused services. They were to be provided with a Universal Service.

2.2.13 In June, the health visitor attended for a developmental review of Child B. Diana was noted as appearing a little overwhelmed and the perpetrator completed all of the childcare during the visit.

2.2.14 Diana saw her GP later in June for her eight-week post-natal check. She had already received treatment for depression and reported that she was in low mood and was particularly concerned about her weight and was offered a weight management programme.

2.2.15 On 17th July and 2nd October, the perpetrator was prescribed Sertraline[15] by his GP.

2.2.16 The perpetrator was prescribed Mirtazapine[16] by his GP on 5th November.

2.2.17 The GP received a letter from Southmead Hospital in November after Diana had been treated there. It was recorded that she had tripped over the stairgate and injured her arm.

Diana's family asked if, during this consultation, she was asked about domestic abuse. The hospital has reviewed the records, and it was not recorded if this was asked. That said, there are now two Independent Domestic Violence Advocates (IDVA) in Bristol and Southmead who work Monday to Friday to support anyone who attends A&E and reveals DA. They also review cases where the symptoms reflect domestic abuse. Staff in A&E can refer for immediate visit. If there is an issue over the weekend the hospital does consider keeping patients in until the IDVAs are next available. IDVAs train all A&E staff on spotting signs of abuse and process. At the time of this consultation paper records were used. These have now been replaced with electronic records and these contain regular prompts to remind practitioners to ask safeguarding questions.

2.2.18 Diana visited her GP again in December. She reported that her chest felt tight when she coughed. She also said that she felt she was suffering from depression again and was prescribed Citalopram.

2.2.19 Diana was seen in the treatment room of her GP in late December when she was concerned that, despite using Slimming World, her weight was increasing. The clinician was unable to refer her to the voucher service so agreed to try to get her an appointment with the local tier 2 service[17]. It was noted that she had a small baby and no transport.

2.2.20 **2015**

2.2.21 In early February Diana saw her GP as she needed a repeat prescription of anti-depressants. She reported that she was feeling much better with the medication and she was having counselling but it was not recorded if Diana was asked, or advised, any details about this counselling. She reported that she felt tired every day and it was noted that she had a 2-

[15] Sertraline is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI) and is often used to treat depression
[16] Mertazapine is also a type of antidepressant used to treat depression
[17] Tier 2 weight management is a mixture of psychological and dietary support suitable for some patients to help them to lose weight. https://www.england.nhs.uk/digital-weight-management/

year-old, a 12-month-old baby and was trying for another baby. It was recorded that this, along with trying to lose weight, may be the reason for the tiredness. She had no thoughts of self-harm or harm to others. Bloods were taken, but no further action was needed.

2.2.22 Diana was seen at home for the children's development reviews. Diana reported that she enjoyed motherhood and would like more children. She told the health visitor that she had fallen over the banister in November. She had been bruised but had recovered. The Family Health Assessment was completed, and no domestic abuse was disclosed. It is not recorded if this was asked.

2.2.23 In March Diana attended the GP for a review of her medication for depression. She reported that she was doing well and felt that she was just about back to normal. She was walking more and had seen the dietician and was losing weight. A referral for exercise was completed.

2.2.24 In July 2015 the health visitor spoke Diana about the Child A's cough. She said that the child had been to the GP a number of times. She was asked to bring the child to the clinic. She initially said that she could not do this as Child A attended nursery. Once it was explained that she could attend on Wednesday when there was no nursery, she agreed. She also gave permission for the health visitor to speak to the nursery, who reported that the child was frequently unwell with coughs and colds.

2.2.25 In September the health visitor had a conversation with the Children's Centre (where Child A attended nursery) who said that they were concerned as the child was frequently unwell and that Diana had said on several occasions that she had to call the paramedics. The health visitor checked with the ambulance service and no attendances were identified. The health visitor advised the Children's Centre that they should consider a referral to children's services if they were concerned. Following this conversation, the health visitor spoke to Diana and suggested a referral to a paediatrician. After discussing this with the perpetrator, Diana agreed.

2.2.26 In early October the Children's Centre asked the health visitor to check the details of the times that an ambulance had been called out and none were recorded. The Children's Centre raised concerns with the health visitor that Diana may be fabricating illnesses.

2.2.27 **2016**

2.2.28 On 8th January Diana's GP received an email from the Weight Management Team. They had received a referral for Diana and were concerned that this was the third time she had requested vouchers for Slimming World. They had spoken to Diana and advised her that the adult weight management service would be more beneficial for her. She was to book to see the service in early March to discuss things further.

2.2.29 In January the Children's Centre met with the primary school ahead of Child A starting at the nursery. The Children's Centre raised their concerns about the possibility of Diana fabricating illnesses. They wanted to ensure that the school were prepared and would monitor for any future concerns. The school said they did not feel that the threshold was met for a referral to Children's Social Care at that time. The school were also advised that the child was being seen by a paediatrician.

2.2.30 The perpetrator saw his GP on 21st January due to back pain.

2.2.31 On 2nd February the perpetrator visited the GP complaining of neck pain.

2.2.32 On 22nd February the health visitor contacted the Children's Centre to provide an update from the paediatrician.

2.2.33 On 15th March Diana was seen at the GP surgery and requested Slimming World vouchers as her friend was already on the programme.

2.2.34 On 18th March the perpetrator saw his GP with back pain following an accidental fall.

2.2.35 The Weight Management Service emailed to Diana's GP on 7th April in which it was explained that they were already in discussion with Diana and had decided that the Adult Weight Management Service would benefit her more and therefore vouchers would not be sent to her.

2.2.36 On 14th April the GP spoke to Diana to explain that vouchers would not be sent out. Diana queried the information as she had been given vouchers in the past but she was advised that she would need to speak to the council about this. She was again offered the Adult Weight Management Service which she declined.

2.2.37 On 26th April 2016 the health visitor had a conversation with the learning mentor from the school as the Children's Centre had raised a concern about 'fabricated illness'. The health visitor reported that the child was under a paediatrician and that the Bristol Safeguarding Children's Board provided guidance about 'fabricated illness'. The school said that the concerns did not meet the threshold and the health visitor reminded the school to refer any concerns to children's services.

2.2.38 On 15th August when a Health Needs Assessment was undertaken, the health visitor saw both the children and noted that they were interacting well with Diana. Diana said that the paediatrician had requested some blood tests, but this was not included in the letter sent to the GP.

2.2.39 **2017**

2.2.40 On 1st February the temporary health visitor was advised of a Team Around the Family (TAF) meeting for 8th February. A Team Around the Family (TAF) is a meeting which brings together a range of different practitioners from across the children and young people's workforce to support an individual child or young person and their family. This typically happens at the early intervention threshold. At TAF meetings the family meets with the different key professionals involved in supporting them to identify needs and strengths of the family. They discuss what support can be offered and create child centred plans that identify agreed goals with the family members if the family agree to the support. Both parents were present at the meeting. (see 2.2.41).

2.2.41 The temporary health visitor contacted Diana to introduce herself. Diana did not know about the meeting.

2.2.42 On 3rd February the health visitor discussed the presentations at the surgery with the GP and all were considered appropriate.

2.2.43 The Children's Centre were concerned about the younger child's non-attendance due to illness. They then raised this with the health visitor on 7th February and suggested that a Team Around the Family (TAF) meeting should be held to share information from health. They also hoped that the meeting would help Diana to fully understand the implications of repeated hospital visits and to ascertain if fabricated illness was a concern.

2.2.44 The health visitor recorded, on 7th February, that there was a discrepancy about the father's view of the TAF meeting. It was noted that Diana had said that he was not interested but he reported that he thought it was a good idea.

2.2.45 Both parents attended the TAF on 8th February. It was noted by the Children's Centre that Child B's attendance had been poor prior to Christmas but had now improved. The Children's Centre reported that Child B sometimes grabbed children around the neck and approached children saying he wanted to cut them. Both parents reported that the child did not have access to scissors at home and this did not happen at home. The parents were advised to attend the Speech and Language Drop In as well as Alive and Kicking, the healthy eating sessions. It was noted that whilst the children's father was keen, Diana was unsure. The reason for this is not known, but her family feel it may have been that Diana was concerned about how she would get to the sessions on public transport.

2.2.46 The health visitor attended for a developmental review on 15th February and both parents were present. The health visitor reported that the children's father appeared to be very engaged and responsive to the children, whilst Diana appeared to be distracted by her phone and raised her voice to her children during the visit. This was discussed with Diana's family and their view is that she may have been on her phone as, with two small children, she did not get much time to herself at other times and she was most likely used to her husband taking charge in these kind of situations.

2.2.47 Diana reported that she had struggled at school and is not able to read long words. The health visitor formed the view that Diana may be exaggerating, confusing or be very anxious regarding the children's minor illnesses. The health visitor made a note of this as it had been suggested that there may have been fabrication about illnesses that was not supported by GP or Consultant Paediatrician. They were offered a Universal Plus service[18].

Diana's family feel that, had her medical records been checked, the fact that she had epilepsy as a child which impaired her learning would have been discovered. We have asked the health representatives to consider this aspect carefully and it would not be the case that a health visitor would routinely check the GP record, unless there was a specific request so to do, or a specific issue such as a safeguarding concern. The details of Diana's reading age as a child would not be readily visible and there was no on-going or current treatment for any epilepsy mentioned.

2.2.48 On 20th February the Children's Centre advised the health visitor that Child B's parents had reported that the child had been in hospital over the weekend.

A further TAF meeting was held on 3rd May. It was reported that both children were progressing well. It was noted that Diana had attended the lunch club that is run in the school by the healthy eating team during the holidays as had been agreed in the TAF

[18] Universal plus offers response from the local health visiting team when specific expert help is needed for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting

meeting. It was noted that Diana was negative with the children, distracted and playing on her phone. Diana reported that all was going well.

2.2.49 On 2nd June the Children's Centre telephoned the health visitor as Child B had attended hospital and had been advised to stay at home for 48 hours and contact the child's GP if concerned. A check at the hospital showed no attendances. The health visitor then attended the home to review the Health Needs Assessment and check on the hospital attendance. Diana said she had called 111 as Child B had frequent loose stools. They had, she said advised her to go to the hospital. When no urine or stool sample could be obtained, she was advised to see her GP in the next week.

2.2.50 On 30th June the health visitor and the Children's Centre discussed the reported hospital attendances of the children. The hospitals were contacted, and the only visit had been on 27th May 2017.

2.2.51 In July the Children's Centre met with the Deputy Designated Safeguarding Lead at the school as part of the handover of Child B from nursery to school. The school said that they were already engaging with the family and would monitor Child B.

2.2.52 Diana attended a family and professionals meeting on 12th July and was encouraged to consider a referral to Early Help. The Early Help team at that time provided support to children, young people and families. There had to be consent from a parent for a referral to the service.

2.2.53 On 4th December Diana saw her GP has over the previous two months she had been generally tired and needed to sleep more. Her bloods were taken. These showed low levels of Vitamin D and supplements were prescribed.

2.2.54 **2018**

2.2.55 Diana contacted the health visitor to ask for a home visit which took place on 29th January. The perpetrator was present as he was home from work sick. Both children were at home with a viral illness. He presented as gentle and calm with the children. Both parents reported that the children responded more positively to their father. The health visitor gave advice about behaviour management, sleep and toilet training. Permission was given for the health visitor to discuss the children with the school. It was noted that both children appeared well, lively and with no sign of illness other than Child B having a runny nose.

2.2.56 On 31st January the health visitor spoke to the headteacher of the school, as well as the Children's Centre. It was reported that both children had poor attendance and the school said that they were concerned that the parents did not always make the right judgement about sending the children to school with minor ailments. The school also reported that Child B's behaviour could be challenging but was not of concern. The health visitor checked the GP records and noted infrequent attendances for both children.

2.2.57 The health visitor contacted Diana on 5th February and advised her that the school were concerned about the children's attendance. She was given advice about the importance of the children going to school even if one is unwell and that they could attend with minor coughs and colds.

2.2.58 Early in May the health visitor discussed with Diana and the GP regarding the second child and their weight loss and lose stools.

2.2.59 Diana telephoned her GP on 17th May as she was having chest pains. These were similar to those she had experienced on and over the past few years. Although she said she was in constant pain, the GP did not think that it was cardiac pain but advised her to come to the surgery. When she was seen later in the day, she had chest pain across her chest and into her left shoulder, with a very tender chest wall. Treatment was given.

Diana's family asked whether domestic abuse was asked about. The pain in Diana's chest may have been due to having been pushed violently by the perpetrator on one occasion or multiple times – her attending the GP may have been because she wanted to disclose to someone. With appropriate questioning Diana may have opened up and discussed domestic abuse. The review acknowledges that the majority of time the cause of chest pain is anxiety, and it is anticipated that the GP would have explored anxiety with Diana and what was causing this. However, having reviewed the GP records again, it is not possible to confirm if this was the case.

2.2.60 On 20th August the health visitor records were closed as Child B started school.

2.2.61 On 27th September Diana was seen at the GP as she had a finger injury sustained at work. The cut was sutured, and she returned on 8th October. On this occasion, the cut was clean and looked superficial and a sick note was given. Diana's family have queried how superficial the cut was if it required suturing. The GP has explained that it is not unusual to suture a superficial wound. It may simply be that superficial has a different meaning between lay and medical professionals. Suturing simply attempts to bring tissue in close proximity to facilitate healing.

2.2.62 In early November 2018 an incident occurred on the school site where Diana alleged that another parent was upset that their child had been hurt by Child B. Diana reported the incident to the head teacher saying that the other parent had knocked into her and barged her with his shoulder. She also said that he was speaking to her in an angry voice 'like men do'. Diana was concerned that Child B may have seen this and been upset. This was followed up with the teacher to ensure the child was not affected by the incident.

2.2.63 **On the day of the incident**

2.2.64 On the day of Diana's murder, both Diana and the perpetrator had taken the children to school in the morning as normal. They attended Child B's school assembly which they both enjoyed. They left the school and went home. Diana telephoned her mother to say how much she had enjoyed the assembly and that she was planning to put up the Christmas decorations.

2.2.65 We know that they went out, during the morning, in the car to a shop together. This was the last time that Diana was seen in public. The last activity on Diana's phone was at 11.49 am.

2.2.66 At the end of the school day, when Diana and the perpetrator did not arrive to collect the children, multiple phone calls were made to both of their phones by the school none of which were answered and went straight to voicemail. Messages were left on the respective voicemails.

2.2.67 Following this a visit to the home was made at by the Deputy Designated Safeguarding Lead (a member of school staff) and it was noted that there was no answer, no lights were on, and the car was not parked outside.

2.2.68 The school were concerned that this was highly unusual and contacted the Safeguarding Education Team (at the local authority) for advice. They were advised to call the police on 101 as all the enquiries that had been made had not been able to establish contact.

2.2.69 At 4.43pm the call was made to the police. The school was advised that enquiries would be made, and the police would be in touch with the school. At 5.21pm the police arrived at the flat and could not raise anyone and noted the car was not outside. The landlord was called by the police at 6.04 pm and he arrived with keys to the flat. Unfortunately, they were the incorrect set of keys, and he returned home to collect the correct keys. At 6.35pm the police collected the children from school.

2.2.70 The flat was entered at 7.02pm and a handwritten note was found propped up on the stairs. This note 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'*

2.2.71 The officers entered the front room and found Diana deceased. She was slumped on the floor with the back of her head resting on the armchair. Ligature marks were clearly visible on the front of her neck. There was no sign of a struggle at the address and no sign of forced entry.

2.2.72 Investigations began to locate the perpetrator. His vehicle had triggered the ANPR database on the M5 travelling northbound at 2.51 pm. His vehicle was eventually located travelling northbound on the M6 in Cumbria at 9.06 pm. He had stopped at a petrol station where he made off without paying for petrol. Having been identified by the police, whilst driving, he drove dangerously and at speed to try and avoid them. Ultimately, the police used a stinger to deflate his tyres and he was boxed in by police cars. When he was stopped, the perpetrator was struggling to keep his eyes open and was unsteady on his feet.

2.2.73 The perpetrator advised the police that there was a bag in the car that contained a knife and that he had taken a quantity of tablets (Sertraline and paracetamol). A search of the car found two mobile phones (one of which was later identified as Diana's), a brown wallet containing the perpetrator's driving licence and bank cards and a black purse containing store loyalty cards in the name of Diana.

Diana's family has asked if these drugs were prescribed to Diana or the perpetrator. When the police searched the family home an empty box of Sertraline tablets was found in the kitchen bin. These were in the name of the perpetrator. This is discussed in more detail at paragraph 3.2.6.5.

Section 3 – Information provided to the review

3.1 Information provided by family and friends

3.1.1 Diana's family and friends describe her as a bubbly, fun loving girl. At school she had lots of friends, and she was described as the life and soul of the party. She was kind and would always look out for the needs of others. Diana was very mature for her age, and we have heard examples of how, as a child, she was stubborn and would stand up to school bullies on behalf of others.

3.1.2 Diana had many interests – music, hair and beauty and travel. She grew up in a village where she would visit the older people who lived there.

3.1.3 When she was aged about three or four, Diana began to have fits which, when extreme, would paralyse her down one side of her body. She was given medication for this epilepsy which her father remembers changed her personality. Her parents remember that at school she was described as having a learning difficulty that she would grow out of. When she moved to secondary school, Diana received additional help from the SENCO (Special Needs Co-ordinator in the school). She attended a number of programmes and the Chair and Report Author have seen certificates that she received during this time acknowledging her work. When she left school at the age of 16 Diana had a reading age of 12.1 and a spelling age of 10.8.

3.1.4 Diana did not want her difficulties to hold her back as is evidenced by the number of courses and programmes that she received certificates from. She was always striving to be the best that she could be. Her school reports continually praised her for her effort, attitude and positive behaviour. When she was 14 years old, her report said that she needed to work on her self-esteem. This review has considered whether this lack of self-esteem could have contributed to how the perpetrator was able to manipulate and control her.

3.1.5 When she left school, although she did not have any GCSEs she attended a pathway course at college and studied hair and beauty and travel and obtained an NCQ qualification. Diana's family are clear that she would not tell people about her difficulties but would just 'get on with it'.

3.1.6 Diana was a hard-working woman who had a number of jobs, all of which played to her strengths, such as a chambermaid, catering and as an Avon consultant. She was definitely not a woman who was lazy.

3.1.7 She would look out for others, even if she did not know them. If she met someone on a bus in trouble, she would seek to help them. Diana had a strong character and knew her own mind. Her family describe how if they gave her advice, they then had to wait for her to think on this and decide it was her idea!

3.1.8 One of Diana's friends described her as being patient with everyone. She talked about a time when she had been upset as her child was misbehaving and Diana had calmed the situation down. She said that she had a lot of respect for Diana and how she dealt with difficult situations.

3.2 Detailed analysis of agency involvement

The chronology sets out in Section 2 details about the information known to agencies involved. This section summarises the totality of the information known to agencies and analyses their involvement.

3.2.1 **Avon and Somerset Constabulary**

3.2.1.1 Within the timeframe for this review, Avon and Somerset Constabulary had one contact with the perpetrator and one with the couple together.

3.2.1.2 In 2010 a doorman refused entry at a nightclub to a group of men including the perpetrator who then became aggressive and started fighting. Several punches were thrown, and the men were restrained before police arrived and arrested those involved. The perpetrator was given a caution for Affray.

3.2.1.3 In 2012 Diana and the perpetrator were woken by two males attempting to steal their car from outside their property. The car was not stolen so no offence was committed.

There are no recommendations for this organisation arising from their actions prior to the Diana's murder. Diana's family are in conversation with the police about a number of learning opportunities that they feel have arisen in their incident management and the subsequent investigation.

3.2.2 **Bristol Community Health (services now provided by a new provider, Sirona Health and Care)**

3.2.2.1 The health visiting service started contact with Diana, following the birth of Child A and continued until Child B started school in September 2018.

3.2.2.2 There was nothing in the Health Needs Assessment undertaken in January 2013 to indicate any significant history that could impact on the parenting ability, so the family was offered a Universal Service.

3.2.2.3 It is noted that in the three visits made to Diana in 2013 either the perpetrator or other relatives were present and therefore Diana was not asked about domestic abuse.

3.2.2.4 In June 2014 the health visitor made a home visit and noted that Diana seemed a little overwhelmed and that the perpetrator completed all the childcare during the visit. The review has considered whether this may have been intentional on the part of the perpetrator to display a particular narrative to professionals and this is discussed later in the report.

2.2.74 When Diana was seen in March 2015, she said that she enjoyed motherhood and would like more children. She told the health visitor that she had fallen over the banister in November. She said that she was bruised but recovered. The Family Assessment was completed, and no domestic abuse was disclosed.

The review notes that although Diana did not specifically disclose domestic abuse, she told the health visitor about an accident that had occurred some three months earlier. The review

considers that this would have provided opportunity for more probing about potential domestic abuse and may have been a missed opportunity.

Further review of the records shows that, in the early years of engagement with the service, with Child A Diana was not asked about domestic abuse as, on each occasion, there were other family members present. However, in later years she was asked on a number of occasions and no domestic abuse was disclosed.

The review is aware that the new electronic system now used requires that it is recorded if the question has been asked and, if it is not asked, the reason is recorded. The new recording system also has a prompt to complete the task at the next contact.

3.2.2.5 In September 2015 the health visitor had a conversation with the Children's Centre about their concerns that Child A was frequently unwell. They said that Diana had reported that paramedics had been called on several occasions. The health visitor firstly contacted the ambulance service, and no attendances were identified. The Children's Centre were advised to consider a referral to children's services if concerns continued. The health visitor then discussed with Diana the possibility of a referral to a paediatrician and advised her to take the child back to the GP. Diana agreed to a referral after a discussion with the perpetrator.

3.2.2.6 The health visitor had a conversation with the learning mentor from the school in April 2016 following a concern from the Children's Centre about 'fabricated illnesses'. The health visitor reported that Child A was still under the care of the paediatrician and that the guidelines from Bristol Safeguarding Children's Board should be followed. The school reported that the concerns did not currently meet the threshold and they were reminded again, by the health visitor, to contact children's services if they were concerned.

3.2.2.7 In August 2016 a Health Needs Assessment was undertaken and both children were seen to be interacting well with Diana.

3.2.2.8 In February 2017 the temporary health visitor was advised of a Team Around the Family (TAF) meeting in a few days' time. The health visitor contacted Diana to introduce herself and Diana said that she did not know about the meeting. There were conflicting reports about the perpetrator's view of the TAF meeting. Diana suggested that he was not interested but he said that he thought it was good idea. Both parents attended the TAF. The Children's Centre reported that Child B would sometimes grab children around the neck and approached children saying that they wanted to cut them. Both parents reported that the child did not have access to scissors at home. The parents were advised to attend for a Speech and Language Drop In. It is recorded that Diana appeared reluctant, but the perpetrator appeared keen.

3.2.2.9 Later in February 2017 a home visit was undertaken by the health visitor for a developmental review. It was noted that the children's father appeared to be very engaged and responsive to the children. The health visitor noted that Diana appeared to be distracted by her phone. She raised her voice to the children during the visit. She said that she had struggled at school and was not able to read long words. The health visitor formed the impression that Diana may be confused, exaggerating or very anxious about the children's minor illnesses. It was decided that Universal Plus service would be offered.

3.2.2.10 A further TAF meeting was held in May 2017 when both children were reported to be progressing well. It was reported that Diana had attended the lunch club but was seen to be negative with the children, distracted and playing with her phone. The lunch club was provided on a weekly basis by the Healthy Eating Team. Diana reported that all was going well, and staff noted that Child A's eating improved.

3.2.2.11 In June 2017 the Children's Centre contacted the health visitor as Child B had attended hospital and had been advised to stay home for 48 hours. The hospitals were checked and there were no attendances. The health visitor attended the home to review the Health Needs Assessment and check on the hospital attendance. Diana said that she had called 111 as she was concerned that the child was passing frequent and loose stools. She said that she had been told to go to the hospital but then explained that it had been the Walk-In Centre. It was confirmed, with GP records, that this was the advice that she was given. They had been unable to obtain a urine or stool sample at the Walk-In Centre and therefore she had been advised to see her GP in the following week.

3.2.2.12 In July 2017 Diana attended a family and professionals' meeting and was encouraged to consider an Early Help[19] referral.

3.2.2.13 In January 2018 the health visitor attended the home following a request from Diana. The children were at home with a viral illness and their father was at home from work sick. The health visitor noted that the perpetrator presented as gentle and calm with the children. Both parents reported that the children responded more positively to the perpetrator. The health visitor discussed behaviour management, sleep and toilet training and obtained permission to discuss the children with the school.

3.2.2.14 The health visitor then spoke to the headteacher who said that both children had poor attendance and the school were concerned that the parents did not always make the correct judgement regarding sending the children to school. The school reported that the second child's behaviour could be challenging but was not of concern. The GP records were checked and showed infrequent attendances for both children. The health visitor spoke to Diana and gave advice about the importance of sending the children to school with minor coughs and colds.

3.2.2.15 In August 2018 the health visitor records were closed as the Child B was now at school.

The review also notes that both children were diagnosed with conditions requiring medication.

The review is satisfied that, since the transfer of services to Sirona Health and Care, routine enquiry about domestic abuse is written into the electronic record keeping systems. This provides practitioners with a reminder and a prompt at mandated Healthy Child Programme visits to explore relationships and domestic abuse. There is an expectation that practitioners will record the reason for not undertaking routine enquiry at a visit.

There are no specific organisations for this organisation.

[19] Early Help provide support to children and families

3.2.3 **Children's Centre[20] - IMR completed by Bristol City Council, Safeguarding in Education Team**

3.2.3.1 The Children's Centre provides part-time day-care for eligible two-year olds and a range of family support services for children pre-natal to five years. The centre aims to work with partner agencies to make an effective and sustainable difference to children and family life chances.

3.2.3.2 Both of Diana's children attended the nursery before moving to school. Diana and her husband were encouraged to access other services at the centre.

The records show that there were a number of times when the Children's Centre raised concerns either about the children or how Diana was coping with parenting.

3.2.3.3 **9th September 2015**

3.2.3.4 The Children's Centre contacted the health visitor as they had concerns relating to Child A and Diana. The health visitor reported that Diana was frequently reporting that Child A was unwell stating that she had called paramedics on a number of occasions.

3.2.3.5 **5th October 2015**

3.2.3.6 The Children's Centre asked the health visitor to check the ambulance service for call outs and none were recorded. This raised concerns for the Children's Centre about Diana's conduct in terms of fabricating illness.

3.2.3.7 **January 2016**

3.2.3.8 A meeting was held with the Deputy Designated Safeguarding Lead (DDSL) at the school prior to Child A's admission to the nursery. At this meeting, the Children's Centre's concerns about Diana fabricating illnesses were raised in order that the school could be prepared and monitor for any further concerns. The school advised that they felt that the concerns did not currently meet the threshold for a referral to Children's Social Care. It was also shared that Child A was being seen by a paediatrician.

3.2.3.9 **22nd February 2016**

3.2.3.10 The health visitor contacted the Children's Centre to update from the paediatrician. It was noted that blood tests had not been requested and the plan was to monitor the situation closely.

3.2.3.11 **7th February 2017**

3.2.3.12 Through conversations with Child B's keyworker and the DSL, the Children's Centre raised a concern with the health visitor about Child B's non-attendance due to illness. They suggested that a Team Around the Family (TAF) meeting was held to pull together information from health to discuss the implications of repeated hospital visits and to ascertain if fabricated illness was a concern. Diana reported that the perpetrator did not think that this was a good idea, however later he said he was supportive of the idea.

[20] The name has been withheld in the interests of anonymity

3.2.3.13 **8th February 2017**

3.2.3.14 The Children's Centre were present at the TAF. They contributed to the meeting by saying that Child B's attendance had been poor prior to Christmas but had since improved. They referred to Child B's behaviour towards other children. It was reported that the child would sometimes grab children round the neck and would approach children saying, *'I want to cut you'.* His parents said that he did not have access to scissors at home and that this does not happen at home. Diana was encouraged to attend some sessions at the Children's Centre and whilst the perpetrator appeared keen, Diana appeared unsure.

3.2.3.15 The actions of the children's centre and the school showed that they had concerns about the behaviour being displayed and acted upon those concerns in a timely manner with due consideration about how the behaviour may have arisen.

This Review has considered whether a recommendation is necessary to ensure that the Children's Centre staff are aware as to how they record their conversations/concerns about domestic abuse. We are confident however, that as has been exemplified by their actions in this case, they are fully aware of the requirement to consider how behaviour may have been triggered and the correct referral process to take. Any recommendation would thus seem unnecessarily bureaucratic and superfluous.

3.2.3.16 **20th February 2017**

3.2.3.17 The Children's Centre spoke with the health visitor to inform them that Diana had said that Child B had been in hospital over the weekend.

3.2.3.18 **2nd June 2017**

3.2.3.19 The Children's Centre contacted the health visitor as Child B was not in following a visit to hospital at weekend. Diana had been advised to keep them at home for 48 hours and contact the GP if she was concerned.

3.2.3.20 **30th June 2017**

3.2.3.21 The Children's Centre had a conversation with the health visitor about reported hospital attendances. The hospitals were contacted and there was only one visit on 27th May 2017.

3.2.3.22 **July 2017**

3.2.3.23 The Children's Centre lead met with the Deputy Designated Safeguarding Lead (DDSL) as part of the nursery handover for Child B moving from nursery to school. The school reported that they were already engaging with the family, and it was agreed that they would monitor Child B's attendance.

The IMR author notes that the Children's Centre actively and appropriately shared their concerns with other professionals where their concerns about fabricated illness could be assessed by medical professionals. The review notes that the none of the other agencies had concerns about potential fabricated illness.

The review also notes that the Children's Centre had concerns about the attendance of both children at nursery and sought to discuss this with the parents. It is noted that, whilst in nursery, the children are not legally required to attend, and the attendance of both children improved when they were in full time education.

3.2.4 **Primary School[21] - IMR completed Bristol City Council, Safeguarding in Education Team**

3.2.4.1 In January 2016, a meeting was held between the Children's Centre and the Deputy Designated Safeguarding Lead (DDSL) of the school. The purpose of the meeting was to provide a handover of all the children that would be moving from nursery to primary school that September. As part of this meeting, Child A was discussed. The Children's Centre shared their concerns about Fabricated and Induced Illness that had been raised with the health visitor.

The review is satisfied that the school acted appropriately in ensuring that all relevant staff were made aware of the concerns. Staff were aware that Child A had to be monitored more closely and any injuries should be assessed through a safeguarding lens and any concerns around attendance were to be raised through the safeguarding team and that there is evidence that this approach was followed.

3.2.4.2 In February 2017 concerns were raised about Child A's inhaler. An inhaler was provided by Diana with a request that the child be given it every day at 11 am. No spacer was provided so this was raised with Diana who then provided the spacer but its use distressed Child A, so it was returned to Diana, and she was asked to practice its use at home[22]. The inhaler was not brought back into school and no inhaler plan was provided by the GP or asthma nurse.

3.2.4.3 The Children's Centre and school met in July 2017 for the annual handover of children starting school in the September. This discussion included Child B. It was noted that the school were already engaging with the family and that they would continue to monitor Child B.

3.2.4.4 In November 2018 an incident occurred on the school site where Diana alleged that another parent was upset that their child had been hurt by Child B. Diana reported the incident to the head teacher saying that the other parent had knocked into her and barged her with his shoulder. She also said that he was speaking to her in an angry voice 'like men do'. Diana was concerned that Child B may have seen this and been upset. This was followed up with the teacher to ensure the child was not affected by the incident. The school noted that the comment made by Diana was unusual and needed to be followed up with her as soon as possible.

The review considers that this is an example of good practice in identifying the need to speak to her again.

Whilst the review cannot be certain, it is acknowledged that Diana may have been upset about her child seeing another man treating her in a similar way to their father.

[21] The name has been withheld in the interests of anonymity

[22] Using an inhaler with a spacer and mouthpiece for asthma ensures the medicine gets deposited into the lungs. Incorrect technique can leave some of the particles from the medicine on the tongue or throat, where it is useless. Inhalers spray the medicine out so that it can be breathed deep into the lungs. A spacer, or holding chamber, is an attachment that should always be used with an inhaler. The spacer holds the medicine in place so it can be breathed in more easily.

3.2.4.5 The DDSL telephoned Diana and she changed some of her account of the incident, now saying that the man had 'brushed past me'. She described being distressed by the incident but made no reference to the man shouting.

Whilst following up with Diana was good practice, the review notes that there is no reference to any probing with Diana about what might have prompted the comment. For example, as part of the conversation, she could have been asked 'how are things at home?' or something similar. Whilst this was not done further action was taken to address the issue, as set out below. In addition, the children and Diana were regular attenders of the breakfast club and Diana spoke with the DDSL regularly. They felt in this case the right approach was to allow Diana to disclose if there was anything to disclose, and if she wanted to.

3.2.4.6 The school then arranged a meeting with both Diana and her husband. The aim of the meeting was to discuss the incident and how the school and home might work together to support Child B and put a plan in place. The school are aware of the dynamics of abusive and controlling relationships and possible power imbalance. The school noted that there was no evident power imbalance with eye contact between both parents and a clearly shared understanding of the issues that were being discussed. It was noted that both contributed to the conversation but that potentially the father was slightly more in control of the conversation but not in a way that appeared to be inappropriate or controlling. The school noted that they saw Diana more often than her husband but that he did attend school regularly.

3.2.4.7 It was noted that Diana was a regular user of the school's breakfast club with her children. This was run by the DDSL. Diana would always go out of her way to say 'hello' and chat with the DDSL. The Children's Centre staff had noted that Diana would spend a long time talking about the children having accidents and illnesses and things that worried her, so the school were prepared for this. This was not, however, the experience of the school. Whilst she did talk about illness issues these were always felt to be appropriate conversations. The DDSL had a conversation with Diana most mornings and felt that she was very caring and her desire to 'get it right' drove much of the communication. For example, she would check information about school trips. Whilst this may have happened more frequently than other parents it did not come across as anything more than caring.

3.2.4.8 Child B was in a group of children in the class who were being monitored in terms of their rough play and the frequency of incidents where children were hurt or upset. The child was able to benefit from targeted interventions, but their behaviour was not considered unusual in the context of the class, and they were improving with the use of a 'behaviour chart' which highlighted key times of the day when their behaviour was challenging. There was no evidence that the school noted of Child B having witnessed violence at home.

Diana's family have asked if Child B was asked about whether they had witnessed violence at home. The review has been advised that the child was not directly asked about whether they had seen violence at home. Conversations between staff and children about what behaviour is kind, safe and appropriate and what behaviour is too rough and unsafe, are typical and usual as children learn to be in the Reception Class environment. Child B was one of a small group in the class, whose play sometimes became too rough and boisterous. This group were spoken to regularly about behavioural expectations and how to play safely. The types of behaviour that were witnessed

included, running too quickly around the playground causing accidental collisions, pushing, deliberately banging into peers, and snatching or taking items from peers causing upset and confrontation. Discussions about being gentle and safe when playing, happened between staff and the small group of children on several occasions in October and November of 2018.

Child B was spoken to individually by the Class Teacher and by the Pastoral Lead regarding their play and the need for fewer incidents where the child had hurt or upset a peer. Classroom staff and the Pastoral Lead discussed this issue with the Child B and Diana on several occasions at the beginning and end of the school day in October and November of 2018. Some of the discussions were celebrating the child's improvements in their behaviour. Nothing in the discussions between staff and Child B had raised any concerns about the child witnessing violence at home.

Diana was, in the view of the review, a concerned parent who developed good relationships with key members of staff and would frequently check to ensure she understood aspects of school life.

3.2.5 **GP surgery for Diana**

3.2.5.1 Diana's GP surgery provided a chronology for the review. Details relating to the scope of that chronology and additional information that has emerged are noted at section 1.3.15 of this report. The surgery did not provide an IMR. However, the GP lead for DHRs and the lead for the Clinical Commissioning Group (now Integrated Care Board) attended all the DHR Panel meetings and were fully involved in the discussions relating to the case and the issues that arose. They were also involved in email and telephone discussions to clarify specific issues that arose.

3.2.5.2 There are a number of occasions when Diana attended the surgery which both may have indicated the possibility of domestic abuse and certainly provided the opportunity to ask how things were at home. For example:

- 5th March 2012 – injury to shoulder and back after she reported falling down the stairs
- 30th March 2012 – attended hospital Emergency department with head injury after she reported falling down the stairs (Hospital notified GP by letter)
- 18th November 2014 – Injury to arm, after reporting that she tripped over stairgate and fell
- 5th December 2014 – anxiety with depression
- 4th December 2017 – Fatigue
- 17th May 2018 – atypical chest pain

The information provided to the review and sight of the records does not make any reference as to whether domestic abuse was considered or asked about when Diana attended the surgery or indeed attended hospital.

The review is conscious that following receipt of the information from the hospital about the incident on 30th March 2012, the GP did attempt to contact Diana. Whilst we cannot be sure, it does seem likely that this was an attempt to follow-up the head injury. This would have provided a further opportunity to ask how the 'routine' or 'selective question' about how things were at home and thus offer the opportunity to Diana to disclose. No one can say whether she would or would not have taken that opportunity had those injuries been caused by abuse or indeed whether she was suffering other forms of abuse or concerns about the relationship.

There is no evidence of any suspicion being aroused following the reported fall and resultant injuries in 2014.

The review considers that, there were missed opportunities, either to ask the question or to record it on the record.

3.2.5.3 The review explored this area with the GP lead, and he was very helpful in setting out his concerns and difficulties in relation to 'routine questioning' back in 2012/2014.

3.2.5.4 The review is aware that the GP practice in question is now an IRIS[23] supported GP surgery and as a result is much more informed and 'alive' to the issues of abuse.

3.2.5.5 For clarity, Identification and Referral to Improve Safety (IRIS) is a specialist domestic abuse education, support and referral programme providing training for GP teams and a named advocate to whom patients can be referred to for support. The review considers that this is a welcome addition and will improve patient safety and in particular the response to potential domestic abuse within the area.

3.2.6 **GP surgery for the perpetrator**

3.2.6.1 The Clinical Commissioning Group were asked to provide details of the perpetrator's engagement with a GP prior to being remanded into custody, and later sentenced to serve time in custody.

3.2.6.2 As he was residing in the prison estate, his records were requested, by the CCG, from the appropriate prison. His civilian GP records are not held by the prison and are not retained at the previous GP surgery, therefore it is not possible to review these records.

3.2.6.3 The first medical entry on the perpetrator's medical record in prison was on 2nd December 2018.

3.2.6.4 **2nd December 2018**

3.2.6.5 The perpetrator was reviewed by a nurse and stated that he had no history of engagement with mental health services. Whilst he said that he had never spoken to his GP, or been treated for anxiety, he reported having been prescribed 50mg of Sertraline several years earlier. His record shows prescriptions on 17th July 2014 and 2nd October 2014. Furthermore, a prescription for Mirtazapine was issued on 5th November 2014. He reported that he had taken this medication for a few weeks and had then stopped.

At the time of his arrest, the perpetrator told police officers that he had, earlier that day, taken a quantity of Sertraline tablets. An empty box in his name was found, by police, in the kitchen bin. The perpetrator had told police that he had started to take medication that he had retained from 2014.

[23] https://pdfhost.io/v/n85PxItbI_Blue_Simple_University_General_Newsletter.pdf

3.2.6.6 Amongst the documents recovered from the family home were two statements of fitness for work dated 29th October 2018 and 9th November 2018. On both statements his condition is described as 'arthralgia of multiple joints'[24].

Given the limited information from the perpetrator's medical records, the review has been unable to analyse these interactions in detail.

Recommendation One

It is recommended that the Department of Health provide guidance to the Home Office to inform DHR Chairs how previous GP records can be accessed.

[24] Arthralgia describes stiffness of joints

Section Four – Analysis

4.1 Evidence of domestic abuse

4.1.1 One of the key roles of a Domestic Homicide Review is to look for a trail of domestic abuse, which may often have been hidden. This has been particularly difficult in this case as, prior to Diana's murder, neither party spoke to any agencies, and very few family or friends, about any domestic abuse. Nor is there any evidence of the children disclosing domestic abuse prior to Diana's death. However, there is evidence that Child B was showing some signs of behaviour at school that was deemed to be aggressive towards their peers. CAFCASS stated, in the Family Court, that the children had been exposed to adult conflict. Since Diana's murder, the perpetrator has said that he was a victim of domestic abuse, but this was not entered by his defence team into the criminal proceedings. He was pressed about this by the Chair and Report Author and provided no examples to substantiate this claim.

4.1.2 Given the fact that he pleaded guilty to Diana's murder, the review has sought to identify any evidence that there may be from what we do know that allow us to form a hypothesis about a trail of domestic abuse. The review is aware that, with hindsight, we can see that there were circumstances that may have been as a result of, or influenced by, domestic abuse.

4.1.3 The Independent Chair and Report Author have been fortunate to have been given sight of the papers presented to the Family Court hearing. These include two interviews with the perpetrator, by a psychiatrist, interviews with both sets of grandparents and interviews by more than one professional with the children. These have proved invaluable in assisting in this line of enquiry. The review has also used the professional expertise of both the Independent Chair, Report Author and panel members in interpreting the evidence.

4.1.4 In presenting the findings of this work, the review adds the following caveats. Firstly, that the perpetrator did not offer any specific examples of the allegations that he made about Diana and her abuse of him, other than one reference to an incident that occurred on a New Year's Eve. Secondly, we have looked to find any evidence that is independent of the perpetrator in order to add weight to his claims. We have found none. Whilst that does not exclude the possibility of it being true, we cannot find corroboration.

4.1.5 The review believes that, on the balance of the probabilities, there is enough evidence to *suggest* that the perpetrator was abusive to Diana. Whilst saying this, the review is very clear that there are only two people who really know the truth. The rationale for this judgement will now be discussed.

4.1.6 **Isolation**

4.1.7 In June 2018 the perpetrator wrote to the nursery to tell them that they would be keeping Child B at home for the final month so that they could get them toilet trained before attending school.

4.1.8 Whilst the perpetrator's family say that they did everything to include Diana in the family, we know that the weekend before she died, the perpetrator went to his parents' home for a birthday celebration without Diana and the children. She was very upset when she telephoned her mother whilst they were out.

4.1.9 Diana's sister has told the review that Diana was keen to move closer to her family so that the children could go to the same school as she had attended. Diana's family have described how the perpetrator appeared to go along with the idea from the outside but has since said that Diana had hated living in a small village and would not want the children to spend their childhood there. This sense of isolating Diana from her family is, when asked, the biggest difference that her family observed as the relationship developed.

4.1.10 Whilst the family had regular contact with Diana and her family, this was always at their home. Diana's parents have said that the perpetrator would often say, 'you must come to ours' but, despite his family visiting regularly, they were never actually invited. The perpetrator would put barriers in the way of them visiting such as saying that Diana's father would not be able to manage the stairs (due to his health) but this was not the case.

4.1.11 Diana's friend said that she had seen Diana less over the past year as the perpetrator had stopped working. It is possible that this was in order that he could isolate her from her friends. Another friend told the review that, over the last year, Diana would let her down much more often. She wanted to arrange to meet for coffee more often than they had previously but would then, more often than not, cancel.

4.1.12 **Physical abuse**

4.1.13 In March 2015 Diana saw her health visitor and told her about how she had fallen over the banister whilst she was going to hang out the washing. Whilst this may have not been the reason for the fall, the review particularly notes that this was an incident that had happened some four months earlier in November 2014. The review questions why she told the health visitor at this time. Could she have been trying to disclose domestic abuse?

4.1.14 As part of the murder investigation, a friend of Diana's told the police that she had known Diana for at least 15 years and that the perpetrator had been violent to her before the couple were married. She had not mentioned any violence since their marriage but had told family and friends in the last week of her life that there were 'problems'; we are unable to say if this comment alluded to physical concerns or other issues within the relationship.

4.1.15 Diana was strangled by the perpetrator. Only he knows if he had tried to strangle her previously, but we do know that 68% of women at high-risk of domestic abuse will experience near-fatal strangulation by their partner[25] and 50% of strangulation victims have no visible injuries[26]. The chances of homicide increase by 75% for victims who have been previously strangled, compared with victims who have never been strangled[27].

[25] 2 Taliaferro, E., Hawley, D., McClane, G.E. & Strack, G. (2009), Strangulation in Intimate Partner Violence. *Intimate Partner Violence: A Health-Based Perspective.* Oxford University Press, Inc., 217-235 cited in Strangulation in Intimate Partner Violence, Training Institute for Strangulation Prevention,

[26] 3 Strack, G.B., McClane, G.E., & Hawley, D. (2001). A review of 300 attempted strangulation cases: Part I: Criminal Legal Issues. Journal of Emergency Medicine, 21(3), 303-309.

[27] 7 Glass et al. (2008). Non-fatal strangulation is an important risk factor for homicide of women. The Journal of Emergency Medicine, 35(3), 329-335.

All cited in Strangulation in Intimate Partner Violence, Training Institute for Strangulation Prevention,

4.1.16 **Economic Abuse**

4.1.17 We know that the couple had debts. These included for instance payday loans, telephone contracts and, that on the day of her murder, the landlord had been chasing for the £3000 that they owed in rent.

4.1.18 By further reviewing the paperwork found in the flat and in the car that the perpetrator used to escape, we have been able to determine the following:
Diana had personal debts that amounted to a few hundred pounds, these appear to be lifestyle debts such as a mobile phone contract. On the other hand, the perpetrator had debts that were far more significant, amounting to several thousands of pounds and were fundamental to the family's living arrangements. These debts included a Civil Court Injunction issued in July 2018 for unpaid council tax, money owed back to his employer following the termination of his employment and other debts. The debts were increasing significantly during 2018 with little obvious means of recovering their financial situation/ employment.

4.1.19 More than one person has told the review that the perpetrator changed the couple's cars regularly. Diana told her father that the perpetrator had, on at least one occasion, been pestering her for her child benefit money so that he could change his car. Diana's father described how he went with the perpetrator on one occasion to buy a car and he handed over the money without having even looked inside the car.

4.1.20 One of Diana's friends told the review that Diana had looked after her children in the past and that she had paid her in party food from her business. The review wonders if she did not have money to buy food for the family.

4.1.21 The review is aware that Diana had sustained a minor injury at work and that the perpetrator wanted her to make a claim being made against the company. We know from Diana's family that they did not consider the injury serious enough for a claim and that the claim was driven by the perpetrator. It is possible that this was seen as a means of resolving some of the financial problems.

4.1.22 We also know that after the perpetrator had killed Diana, he used Diana's bank card in attempts to obtain money. The Judge said in sentencing "*It is certainly the case that the couple had money problems, with debts, financial pressures, and substantial issues over employment, to alleviate those problems. After the killing, he tried to use (Diana's) bank card in cash machines but twice got her PIN number wrong, and was unsuccessful, therefore, in making a withdrawal. The chances, it seems to me, were that he was trying to obtain some money to enable him to get away, as far as he could, from the area. He drove north for about 300 miles. En route, he made off from a petrol station without paying, thereby confirming his lack of funds"*

4.1.23 Whilst Diana did have funds in the account that was in her name only, the perpetrator's debts were such that it may be that he had no ready access to cash, thus his only option was to use Diana's card. This may be the case, but equally it may be that he was seeking to lay a false trail after her death.

4.1.24 Many couple's find themselves in debt. It would be wrong to say that debt in every case is a sign of abuse. However, in this case, the evidence seems clear that the perpetrator was

the one who got the couple in debt by living beyond his means and increasing debts month on month. He wanted Diana to take action against a previous employer as a means of getting cash to repay their debt. There is little evidence of him finding employment to attempt to manage the debt in a more sustainable way.

4.1.25 **Coercion and control**

4.1.26 The nursery said that they felt more confident that things had been understood if the perpetrator was there (although the school did not share this view). We know, from the school too, that Diana would often ask about arrangements for trips etc to make sure that she had correctly understood. One of the means of abuse is to undermine the victim and make her believe that she is useless, that she cannot trust her own judgement and is not a good mother. There is evidence of the perpetrator portraying himself to professionals as the more competent parent in almost every meeting he had with them. For example, in January 2018 the health visitor went to the home and recorded that the perpetrator presented as gentle and calm with the children.

4.1.27 In January 2017 there was an incident where Diana was asked, by the nursery, about the value of holding a meeting to discuss their concerns. Diana responded that she would have to speak to the perpetrator. A few days later she was asked again and said she had not asked him and changed the subject. She finally said, a few days later, that she had asked him, and he had said that he would not attend but resolve the matter himself with the paediatrician. The nursery noted that when they asked him about the meeting, when they saw him at school, he said that he knew nothing about the meeting and would be happy to attend. This could demonstrate control over Diana by him, both refusing to accept the meeting and undermining her when he was spoken to by the school. Diana was obviously reluctant to speak to him about it.

4.1.28 Later in June 2017 the nursery talked to Diana about referring her to Early Help. Her response was that she would have to ask the perpetrator. She later responded by saying that she did not need the help.

4.1.29 Diana's mother commented that she thought that Diana was very house-proud but when they went to the flat after her death, she described it as looking like a 'car boot sale …. a hoarder's house'. A friend also told the review that the flat was always 'messy' and that in the kitchen you could not see the worktops. She too said that there was 'stuff' hoarded all over the flat. One interpretation of this change in behaviour could have been the influence/control by the perpetrator in preventing her from keeping the house looking tidy as Diana's family said she was 'the tidy one' of their family and she 'would not have wanted to live like this'. There may be other explanations, but this change of habit is notable.

4.1.30 Diana's friends and her mother-in-law described her as not being the most reliable of people, who would cancel social meetings at the last minute. This, along with a friend saying that the perpetrator would turn up at social events that she would not expect him to be at, suggests control.

4.1.31 In the days before her death Diana's friend had seen her at school and she had sat in her car and chatted to her, but she said that Diana could not stay long as the perpetrator was parked nearby.

4.1.32 When he was talking about the day of the incident, the perpetrator described how he went into the lounge to get his headphones, 'that he had loaned to Diana'. In some circumstances this could be considered to be an unusual way for a man to describe an interaction with his wife. It gives the impression of him being very clear about what belonged to him. However, it is also accepted that it could be a 'figure of speech'.

4.1.33 One of Diana's friends has told the review that if she had a party, she would always invite Diana and that she was always the first to arrive and the first to leave. For example, if the party was due to start at 7pm she would be there at exactly 7pm and would leave after a couple of hours. She would say that she needed to get the perpetrator's tea. She gave the impression that she did not want to let down her guard when she was out. She would not have a drink and would not bring the children.

4.1.34 This friend also talked about how Diana found hosting social occasions difficult. She referred to an occasion when she and her sister-in-law had been invited by Diana to go to her home. She had laid on a buffet for them and they thought that they were invited for the evening. All of a sudden Diana announced that they would have to leave as the perpetrator was due home.

4.1.35 One of Diana's friends said that they were really close and were a very tight family unit as they were always together. Whilst this may have been the case, the review is aware that where coercion and control is present in a relationship it can be perceived in this way to those outside.

4.1.36 The Chair and Report Author spoke to Diana's family about how she had changed when she met the perpetrator. They said that, initially, he was besotted with her and could not do enough for her. The review is acutely aware of the part that the initial 'love-bombing' plays in the development of an abusive relationship. Diana's father said that she was not as open as she used to be. She had always been really affectionate, 'a daddy's girl'. She had a really positive relationship with her father and would want to go out with him on errands etc. When she met the perpetrator, she was not as affectionate and appeared more 'on her guard' when she was with him. Diana's father talked about her telephoning him on a number of occasions, and he sensed that she just wanted to hear his voice, that this soothed and calmed her.

4.1.37 **Manipulating the impression and narrative that professionals had of the family**

4.1.38 When looking with the benefit of hindsight, one interpretation of the perpetrator's behaviour is that the control that the perpetrator exercised over Diana was evident in his interaction with professionals. This is, of course, looking at it through the lens of a domestically abusive relationship and in the search for a trail of abuse. It is acknowledged that another view may be that he was supporting Diana by taking his role as a father to the children, positively. The fact is that he was almost always present when Diana and the children were seen by professionals.

4.1.39 In June 2014 when the health visitor made a home visit it was noted that Diana seemed a little overwhelmed and that the perpetrator undertook all the childcare during the visit. One view of this is that it may have been a ploy on the part of the perpetrator to portray himself in the role of caring and competent father whilst at the same time giving the impression that Diana was unable to cope as well as him. He may, of course, have simply been genuinely helping.

4.1.40 When Diana was told about the Team Around the Family meeting in February 2017, she suggested that the perpetrator was not interested but he then told professionals that this was not the case and that he thought it was a good idea. When the couple were advised to attend the Speech and Language Drop-In professionals noted that whilst Diana appeared reluctant, the perpetrator was very keen. One possibility is that Diana was fearful about what the perpetrator might say about this at home and concerned about how she would access the session, whilst the perpetrator, once again, portrayed himself as a compliant and caring parent.

4.1.41 This manipulation of the presentation of the family continued later in February when the health visitor attended for a child's developmental review and the health visitor noted that Diana appeared distracted in the meeting and when Diana had attended the lunch club she had been distracted and playing on her phone. This is possibly a symptom of the pressure that Diana was facing in her abusive relationship.

4.1.42 On 29th January 2018 Diana contacted the health visitor to ask for a personal visit and the perpetrator was present for the visit. It was noted by the health visitor that he presented as gentle and calm with the children. It was noted that both Diana and the perpetrator said that the children responded more positively to their father. Diana was not spoken to alone and so we cannot be certain that Diana knew that she had to agree with him.

4.1.43 When the school arranged a meeting with the couple in November 2018 it was noted that, whilst they both contributed, the perpetrator was more in control of the conversation. However, it was said that this was not in a way that was inappropriate or controlling. This may have been because he successfully manipulated the situation, it may have been that he was simply more comfortable speaking than Diana.

4.1.44 **Evidence from the children**

4.1.45 CAFCASS stated that the children had been exposed to adult conflict but did not specify more details. The school described Child A as being 'hyper-vigilant' and 'very jumpy' with loud noises. They gave an example of Child A being aware of a classroom door being opened behind them with none of the other children had noticed.

4.1.46 Child B has said to professionals, without prompting, that daddy used to smack them on their legs and that daddy smacked mummy. This was disclosed after Diana's murder as part of the subsequent investigations.

4.1.47 Child A has stated that daddy only loved them but not Child B, but mummy loved them both.

4.1.48 Child A is acutely aware that the perpetrator's family did not like Diana. Child A had heard telephone conversations and adult conversations that have confirmed this.

4.1.49 **Evidence of control since her death**

4.1.50 The review is aware that the perpetrator has continued to control Diana and the narrative that he would have people believe since her death.

4.1.51 Diana's family have talked about the children being christened. Prior to Diana's death, this was all arranged for the village church that they attend. However, it had to be postponed as

the perpetrator's brother had not been christened and therefore could not be a godfather. Since her death, the perpetrator has said that Diana did not want the children to be christened. He also said that she had wanted to be cremated, when her family had arranged a burial in the local churchyard. It is of course possible that she had said different things to each.

4.1.52 The perpetrator has repeatedly talked about Diana not being able to look after the children, but this review has demonstrated, through information from the school, that she was regularly collecting the children and was a good mother. When he was asked about disciplining the children, he said that she was inappropriate. He gave an example of an incident of Child B running out into the road and Diana's response. In the view of the report author, her response was proportionate and not dissimilar to that of any other mother.

4.1.53 **Considerations of the panel**

4.1.54 The panel has considered the allegations made by the perpetrator, alongside comments that have been made by friends and family, as well as professionals. Some of these have caused concern for the panel but we can never really know the truth as only Diana could tell us this. For completeness this is discussed here.

4.1.55 The review has heard from professionals who have said that Diana would report to them minor ailments and would report incidents that had occurred such as going to hospital with the children that cannot be substantiated. We have been told that the children would be kept home from school with relatively minor ailments. We have considered whether one hypothesis for Diana's desire to keep them off school was because when they were at home she felt safer. There is no evidence that this is the case, but it is a possibility for someone who is suffering in an abusive relationship.

4.1.56 This issue has already been discussed earlier in the report, with some professionals suggesting that this was not such an issue as others felt. We know, from interactions with the health visitor and other professionals, that Diana loved being a mother but, as recorded within the health visitor notes, found motherhood somewhat overwhelming after the birth of Child B. It is possible that this was due to Post Natal Depression and other depression that she had experienced earlier in her life, now exacerbated by domestic abuse. We have reviewed the source material as to why it was recorded that she considered 'motherhood overwhelming'. Given all the circumstances that faced her at the time and the way in she, the perpetrator and the children were presenting to professionals, it is not an unreasonable description of Diana's state of mind. There is no evidence that domestic abuse was considered as a cause of that state of mind.

Diana's family have asked if post-natal depression was ever explored by the GP. The records have been revisited and the indicate that the GP mainly concentrated on depression in general, which would usually encompass a holistic approach. A further review of the record found that the specific details of the conversation were not recorded. This is an area that has been identified for a reminder of the specific issues of post-natal depression and will feature on a learning brief that will follow this review.

4.1.57 Having heard from family, friends and professionals the review is left with an impression of Diana as young woman who wanted to be liked and engage with family, friends and those that she came into contact with such as her children's teachers. It appears that Diana was a woman who was keen to please but did not find that social interaction came easily or

naturally to her as she was shy and not as confident as some may have thought her to be. Therefore, she appears to have had a relatively small group of friends and it is acknowledged that the perpetrator may have prevented her from having a wider circle of friends. We have heard from these friends about how she spent a lot of time on her phone, particularly on Facebook and one of her friends said that she mainly communicated with her by text. It is very probable that Diana found this a 'safer' place to communicate with people. Perhaps she was not good at reading non-verbal communication and found it easier to communicate this way. Her friends described her as 'all or nothing' and 'very full on'. It was said that friendships would be 'full on' when first meeting and then they would fall away.

4.1.58 It is possible that the amount of time that she spent on her phone and Facebook was due to her insecurity and lack of confidence or it may have been a means of escaping the reality of her abusive marriage. One friend said that she would document on Facebook all the good things that she and her family were doing. Perhaps she was reaching out to be friends with people but did not know how to do this. Perhaps she was trying to create an impression of a happy family when this was not the case. Her friend said that she had a lot of acquaintances but not many close friends.

4.1.59 A number of professionals referred to Diana as being on her phone a lot of the time, sometimes when it was inappropriate, such as when being visited by the health visitor. There could be a number of reasons for this. The perpetrator would suggest that she was disinterested in her children but might be that she was using it as an avoidance tactic to prevent probing by professionals and to avoid eye contact. We have heard that Diana was not always proficient in picking up on social cues and it might be that she just did not realise that this was not appropriate.

4.1.60 Alternatively, it might simply be that Diana was, like many other people, 'addicted' to using her phone. When asked about this her family said that she was always on her phone. Her mum remarked that she would say, 'you have come to visit us not to sit on your phone'. This is not uncommon with many people in society today and the review is conscious of not reading too much into this.

4.1.61 When this report was shared with Diana's family, documents from her education were shared with the Chair and Report Author that indicated that, whilst at primary school, Diana had additional help due to her 'learning difficulties'. This additional information has been set out earlier within this report and it places the observations of professionals in a very different light. If each of the instances considered is revisited with an understanding that Diana had a reading age of 12 and a spelling age of 10.8 (at the age of 12) a very different picture emerges. This, coupled with the abuse that Diana was experiencing, helps us to understand her reactions and actions.

4.1.62 The review has also learned, from Diana's school reports that she was encouraged to work on her self-esteem. We know, from information from Diana's family, that she was lacking in confidence in some areas. For example, she had learned to drive but had not taken her test. The perpetrator did nothing to encourage Diana's self-esteem in this area and actively discouraged her from passing her driving test. Not only would this have impacted on her confidence, but it would also have isolated her and ensured she remained dependent upon him.

4.1.63 This new insight leads us to believe that, had this been known to professionals, their interactions with Diana would have been very different. The problem is that it was not

recorded on her medical records and therefore there is no means by which they could have known. On one occasion, Diana told a professional that she had struggled with reading long words but, other than this, she did not specifically tell anyone. There are a number of reasons why this might have been so. She may have been fearful about how this information would have been received. She may have feared that the scrutiny of her parenting would be increased further and that she would be judged because of this. We also know that she was lacking in self-esteem which the perpetrator fed. Diana's family believe that, since her childhood, she had always sought to 'just get on' with her situation and would not have told anyone. Very sadly, had professionals known of her difficulties she may have been offered additional support.

4.1.64 The review is very clear however that it was not Diana's vulnerabilities that held her back but rather the abuse that she experienced at the hands of the perpetrator.

4.2 Why did Diana not feel able to report if she was experiencing domestic abuse?

4.2.1 An important question for the review to consider is why neither Diana or indeed the perpetrator, if they were experiencing domestic abuse, felt able to reach out to agencies that could help them or able to really tell their family and friends.

4.2.2 When we consider why Diana did not report any abuse, we know that she had told a friend, before they were married, that the perpetrator had been violent towards her. We do not know what this friend said to Diana and if seeking help from agencies was discussed.

4.2.3 We also know that Diana was reluctant to discuss the problems with her parents. The review has been told about when Diana was spending a lot of time with her father when he was in hospital. Her father recalls that she would talk quite openly about the children but would not talk about her relationship with the perpetrator. Diana's mother has said that if she tried to talk to Diana about things and the perpetrator was in the room she would try and stop the conversation. In the weeks leading up to her death, Diana's mother wondered if there may be money worries but when she asked about this Diana denied it.

4.2.4 Diana's mother disclosed to the review that she had previously been a victim of domestic abuse and she felt that, because of this, Diana would not talk to her. She said that women who are abused will not talk about it until they are ready.

4.2.5 The review notes that, because the perpetrator was present during meetings with professionals, it made it very difficult for professionals to ask about domestic abuse in the relationship.

4.2.6 The review is aware that a DHR published by a neighbouring CSP[28] identified the need to conduct research into the barriers to reporting domestic abuse to third parties with a view to overcoming these barriers.

Recommendation Two

It is recommended that the CSP reviews the research undertaken by this neighbouring CSP and looks to use the findings to inform future strategy, policy and practice in Bristol.

[28] https://saferstrongerns.co.uk/wp-content/uploads/2020/03/DHR-4-overview-report.pdf

Recommendation Three

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.

4.2.7 During the interview with the perpetrator by the Chair and Author, he said he had in fact been subject to abuse by Diana but had not told anyone. He gave, what he said were examples of this, but said that he was ashamed. None of his information is verified within any records of any organisation nor was it offered to the police or courts as part of his defence. It does, therefore, have to be treated with caution in respect of its probity. He was however asked what might have made it easier for him to tell someone. He said that an independent phone line where he could speak to someone in confidence so that he would not worry about it getting worse. It was not appropriate, given the point in the interview when this was discussed, to probe further about whether he had ever looked for such a helpline. In relation to Diana's murder, he said they had argued that morning and that he 'just snapped'.

4.2.8 Many Domestic Homicide Reviews have identified that there is a lack of understanding amongst the public about what support is available. A Google search for 'I am a man experiencing domestic abuse where can I get help' brought up the following results:

- National Domestic Abuse Helpline – *when following this link there was nothing about male victims although, if called, they will signpost male victims to the Men's Advice Line*
- Support for male survivors – Women's Aid – *this led to a page specifically for men with the number/email address for Men's Advice Line*
- Support for men – Refuge Charity – Domestic Violence help – *this provided the number/email address for Men's Advice Line*
- Domestic abuse: how to get help – GOV.UK – *provides information about Men's Advice Line*
- Domestic abuse – men helplines – This Morning ITV[29] - *This contained a link to Mankind and the Men's Advice Line*
- Male victims of domestic abuse – Reducing the Risk – *Provided details of Safeline, Survivors UK, Men's Advice Line, Mankind*
- Getting help for domestic violence and abuse – NHS – *Provides details of Men's Life Advice and Mankind*
- Domestic violence and abuse – getting help – Citizens Advice – *Provided details of Men's Advice Line, Mankind, SurvivorsUK and Everyman Project*

4.2.9 This review has considered whether it is appropriate to include recommendations relating to male abuse. After discussions with the Keeping Bristol Safe Partnership, it was felt that this review must retain its focus on a young woman having been murdered by her husband. On balance, given the lack of any corroboration as to his assertions of being a victim, to include recommendations relating to male abuse could cause unjustified imbalance in this report. In addition, the area has unfortunately, suffered other male abuse cases where there is strong evidence for recommendations to support and it was felt that those recommendations are in progress, in relation particularly to the case of 'Jonathon'. These

[29] Published on 1 May 2020

recommendations were identified in the review into the death of a man completed in December 2018.[30]

4.3 What happened on the final morning? And what led to Diana's murder?

4.3.1 As has been previously stated in this review, there are only two people who know exactly what happened on the morning of Diana's murder and why this led to her losing her life. What was it that prompted the perpetrator to act in the way that he did and strangle Diana?

4.3.2 What we do know is that the psychiatrist that saw the perpetrator as part of the Family Court process said that there was nothing that suggested he was suffering from a significant mental disorder. The judge in sentencing said that despite her efforts Diana could not break free from the item around her neck and said, 'I conclude that the perpetrator intended to kill her' although it was not pre-meditated.

4.3.3 If we revisit the events of the morning, the couple had been to the school for an assembly. They had returned home and then were seen to have gone to a shop before returning home. We know that Diana had enjoyed the assembly and had told her mother that she was planning to put up the Christmas decorations, and there is evidence that she had begun to do this. So, what were the conversations that led to her death?

4.3.4 There is a suggestion that, on that morning, a letter had arrived from the solicitor advising them that they would not be likely to receive compensation for the injury that Diana had sustained at work, but the review has been unable to verify this. We do know that the perpetrator was under pressure to repay the outstanding rent that was due.

4.3.5 It may be that this stress over finances played a part in the conversations that took place. The review has also considered another possibility.

4.3.6 One of Diana's friends has told her parents that Diana was unhappy and was wanting to separate from the perpetrator. Diana's sister has told us that Diana put a post on Facebook saying that, at Christmas, it was going to be just her and the children. The perpetrator has told the review that Diana had spoken about getting a live-in job so that she could get away. He also has said that Diana had said that he and his family would not see the children at Christmas or in the future.

4.3.7 Whilst we cannot be certain, there is enough known to lead the review to consider that Diana may have been planning to leave the relationship.

4.3.8 Research tells us that the point at which an abusive relationship ends is highest risk for victims, in terms of homicide. The likelihood of the violence increasing after separation is huge. 55% of women killed by their ex-partner in 2017 were killed in the first month of leaving and 87% within the first year[31].

[30] https://www.bristol.gov.uk/documents/20182/35168/Jonathan+DHR+Overview+Report.pdf/681d067f-52ae-a164-aa42-d99342be0fc1
[31] The Femicide Census, 2017 findings, Published in 2018

4.3.9 The judge concluded, on the evidence presented at the trial, that Diana's murder was not pre-meditated. Although the note left by the perpetrator is a form of evidence, it does not provide the reason. Only the perpetrator knows what happened.

4.4 Development of Bristol's approach to domestic abuse

4.4.1 Much has been done in recent years to add rigour to Bristol's approach to domestic abuse.

A Mayoral Commission on Domestic Abuse sets out the response to domestic abuse and sexual violence with seven principles and 35 recommendations that underpin the City's response. This is a positive move forward.

4.4.2 The commission was supported by a wide range of local and national organisations including those with a statutory responsibility for safeguarding, supplemented by specialist support services.

Section Five – Lessons Identified

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.

An early learning brief was produced in this case in order that all organisations captured the nature of domestic abuse that has been highlighted. That brief is duplicated below.

Domestic Homicide Review
Learning Brief

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

Review into the death of Diana in 2018

The Keeping Bristol Safe Partnership are undertaking a Domestic Homicide Review into the death of Diana.

Diana was only 33 years old when she was killed by her husband in 2018. The couple had two young children. There had been no prior reports to agencies of domestic abuse between the couple.

The Review has scrutinised the information that is available to it and concludes that it is likely that Diana was subjected to abuse by her husband for much of their six-year marriage. That abuse may not have been physical violence, but other forms of abuse can be destructive and debilitating for victims who often suffer in silence. In some cases, some victims may not realise they are subject of abusive behaviour until it is too late.

Whilst no prior reports of abuse were made in this case, the victim and her husband were known to a range of local agencies, almost exclusively because of issues that emerged with their young children. Diana herself was involved separately with health services because of anxiety and depression. This review has looked at what can be done to better afford victims the opportunity to recognise and disclose abuse.

Abuse in this case may have included:

Economic abuse – the husband ran up debts that placed the family's rented home in jeopardy and added to the anxiety and stress suffered by the victim. Those debts appear to have been accrued because of a misogynistic attitude where 'he did what he wanted' whilst the victim struggled with the children. The husband encouraged Diana to take legal action over a minor fall at work as a means of covering his spending.

Isolation – Diana's parents and sister were never invited to their home, and she was unable to see her friends in the year prior to her death when he lost his job.

Controlling and Coercive Behaviour – Diana appeared to have to run all decisions past her husband to the smallest degree. During the times that she had seen friends she always had to leave early to 'get his tea'. During the time when friends were 'allowed' to come to the flat they always had to leave before he returned home. People always describe Diana as being 'on her guard' after she met him, careful of what she said. Her levels of anxiety and depression, in particular, weight problems she encountered left her susceptible to bullying, whether it be direct or subtle, by her husband.

Signs within the children's behaviour – agencies were concerned about both children's poor attendance in their nursery/school settings. In addition, one of the children displayed behaviour that was concerning. Diana was suffering from depression and was overwhelmed by looking after the children. The agencies did liaise together and obtain information from the parents and offer support packages. However, none of the agencies were able to evidence that they considered whether domestic abuse may have been a factor in the relationship. It is possible that Diana may have been keeping the children from school as a protective factor for her, and the behaviour of her child may have been as a result of witnessing domestic abuse and violence.

There is no diagnosed mental ill-health on the part of the husband in this case therefore, whilst there may another version of events that could explain each of the various examples

of behaviour displayed in this case, the fact that he ultimately killed Diana, does make it reasonable to conclude that he was also abusive to her.

As a result of this review, we urge staff within agencies to consider whether domestic abuse, in any of its insidious, awful forms, may be present as a backdrop to people presenting in need of support or when behaviours that may appear out 'of the norm' arise.

'Think Domestic Abuse'

Section Six – 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.

Section Seven - Conclusions

6.1 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.

6.2 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.

6.3 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.

6.4 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.

Appendix One – Terms of Reference

BRISTOL Domestic Homicide Review (DHR) Re: Diana
Terms of Reference

The Terms of Reference

The purpose of this review of the death of **Diana**

- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.

- Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon 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 homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- Highlight any fast track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

2. Overview and Accountability:

2.1 The decision for Bristol to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Keeping Bristol Safe Partnership and the Home Office on 13/05/19.

2.2 The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review.

2.3 This Domestic Homicide Review is committed to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner, within the spirit of the Equalities Act 2010

3 The Domestic Homicide Review will consider:

3.1 Each agency's involvement with Diana from 1st January 2007 (being the beginning of the relationship) and her death except for any other relevant information relating to domestic abuse prior to this date. Whilst checking these records we will aim to identify any other significant individuals who may be able to help the review by providing information.

3.2 Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim or her children, prior to the homicide (any disclosure, not time limited).

3.3 In relation to the family members, whether there were aware if any abuse and of any barriers experienced in reporting abuse? Or best practice that facilitated reporting it?

3.4 Could improvement in any of the following have led to a different outcome for Diana considering: -

a) Communication and information sharing between services with regard to the safeguarding of adults

b) Communication within services

c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

3.6 Whether the work undertaken by services in this case are consistent with each organisation's:

a) Professional standards

b) Domestic abuse policy, procedures and protocols

3.7 The response of the relevant agencies to any referrals relating to Diana concerning domestic abuse or other significant harm from the perpetrator. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:

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

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

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

m) The quality of any risk assessments undertaken by each agency in respect of Diana and her children.

3.8 Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

3.9 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.

3.10 Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

3.11 Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

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

3.13 Keep these terms of reference under review to take advantage of any, as yet, unidentified sources of information or relevant individuals or organisations.

4. Media Strategy

4.1 A single point of contact has been identified to field all media enquiries in relation to this DHR and a position statement of "no comment" will be offered until the conclusion of the DHR process and sign-off of the overview report by the Home Office Quality Assurance Panel.

Appendix Two – Questions raised by Diana's family

2.1 Diana's family asked a number of specific questions for the school which were answered in their IMR. These are set out below.

2.2 **Who was nominated at the school to pick up the children if Diana or the perpetrator were not available to do this?**

2.2.1 At the beginning of each academic year, the school requests from parents, additional contacts. Diana and the perpetrator were consistently on the contact list. One year, when Child B was in nursery, a friend of Diana's was listed but this was not repeated in subsequent years. Whilst it is advised that a minimum of three contacts is provided, this is not compulsory, and it is not unusual for parents to provide only one or two emergency contacts. At no point, were the contact details of either set of grandparents provided.

2.3 **What was the school's reason for calling the police on the day of the incident?**

2.3.1 The school had made reasonable attempts to contact Diana and the perpetrator when the children were not collected from school. Multiple phone calls were made to both of their phones which did not ring and went straight to voicemail and messages were left. A home visit was made by the DDSL and there was no answer, the flat was in darkness and there was no car parked outside. The school were concerned as this was highly unusual and so sought advice from the Safeguarding in Education Team at Bristol City Council. They were advised to call the police on 101 as they had not been able to make contact. The call was made, and the school were advised that enquiries would be made and that that police would be in touch. The police collected the children from school at 6.35 pm.

2.4 **Did the school suspect that there was anything wrong at home with the children?**

2.4.1 The DSL and DDSL are very experienced practitioners who have considerable experience working with families that are experiencing difficulties. The school did not see anything that led them to believe that they were concerned. If they had been, there were robust systems in place to act.

2.5 **Did the children have a lot of time off school?**

2.5.1 Child A's attendance showed improvement over time:

Nursery year 1	52.6%
Nursery year 2	66%
Reception	83%
Year 1	95.5% (up to the date that they left)

2.5.2 Child B's attendance had also shown some improvement:

Nursery	48.8%
Reception	85.7% (up to the date that they left)

Appendix Three – Live DHR action plan

Recommendation	Scope of recommendation ie local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
DEPARTMENT OF HEALTH						
That the Department of Health provide guidance to the Home Office to inform DHR Chairs how previous GP records can be accessed.	National	The Home Office to request the Department of Health to provide the guidance The information is provided to the Home Office The Home Office to make this information available to CSPs and DHR chairs	Home Office Department of Health Home Office	The Home Office to request the Department of Health to provide the guidance The information is provided to the Home Office The Home Office to make this information available to CSPs and DHR chairs	Home Office to decide the achievable timescales	When this is complete, CSPs and DHR chairs will be clear how GP information can be accessed thereby reducing delays in the completion of DHRs and ensuring the relevant information is available
KEEPING BRISTOL SAFE PARTNERSHIP						
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	Local	KBSP to request that North Somerset CSP share their learning from the research undertaken on barriers to reporting for third parties. This was a	KBSP Domestic Abuse and Sexual Abuse Delivery Group	KBSP Business Unit to request that research is shared by North Somerset CSP. DASV DG chair to ensure this research is added	December 2022 January 2023	Complete. The KBSP contacted North Somerset who shared a Family and Friends Advice Booklet which was the end product of the research undertaken for third party reporting. This was similar to a Bristol resource and

		recommendation from the North Somerset DHR for Sharon (2018). KBSP DASV Delivery Group to consider this research as an agenda item and consider whether changes to strategy, policy and practice are required in light of the research findings.		to agenda for discussion. DASV DG to review research and consider whether changes to Bristol strategy/ policy/ practice are required.	March 2023	North Somerset credited Bristol for their work. The latest information on advice for family and friends is already included in the Bristol Family and Friends advice booklet which is available as a resource on the KBSP website. Learning from the Diana DHR will be included in the Domestic Abuse Strategy, the Prevention theme will include how friends and family can help.
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.	Local	KBSP business unit to ensure that signposting to domestic abuse services in the city is included in the KBSP social media strategy, specifically during international/ national/ regional awareness raising campaigns for example, international day of the elimination	KBSP Business Unit	Update the KBSP Social Media Strategy and agree with all members responsible for social media in the team. Write to domestic abuse services to ask how they use all types of social media in their communications strategies.	January 2023 January 2023 January 2023	Complete. KBSP worked with Public Health (commissioners for Domestic Abuse services in Bristol) and planned a social media strategy to raise awareness of domestic abuse during the November 2022, International Day for the elimination of Violence Against Women, White Ribbon Day, and the 16 days of action on all platforms. This included sharing campaigns on

	of violence against women. KBSP business unit to seek assurance from the domestic abuse services commissioned in Bristol (Next Link Plus) that social media is utilised in their communication strategies and awareness raising campaigns.	Advise services that as a finding of this DHR, use of all types of social media should be considered in their messaging.	twitter and KBSP website, KBSP newsletter & BCC Twitter, sharing KBSP training on domestic abuse and safeguarding, resources and links to support services such as Next Link. The KBSP also hosted the Domestic Abuse and Safeguarding webinar during Stop Adult Abuse Week 2022, links to this was shared on all social media platforms including twitter and it was recorded and put on the KBSP website. KBSP also contacted the Domestic abuse service who confirmed that they do utilise most social media platforms where appropriate such as Twitter, Website, Instagram & LinkedIn and also provide awareness raising training for their services.

Appendix Four – Home Office Feedback Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Lorena Evans
Statutory Review Officer
Keeping Bristol Safe
Partnership KBSP Business
Unit (City Hall),
Bristol City Council, PO Box 3399,
Bristol
BS1 9NE

22nd February 2024

Dear Lorena,

Thank you for resubmitting the report (Diana) for Bristol Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in February 2024.

The QA Panel felt this was a sensitive report that had good involvement from family and friends, with a moving tribute which provided helpful insight into who Diana was and gave her a voice throughout. It was positive to see engagement with the perpetrator which added insight.

The QA Panel felt the language used around 'seeking the trail of domestic abuse' was positive and gave an emphasis on the likelihood of domestic abuse being apparent prior to Diana's death and rightfully raised concerns that Diana was never asked about domestic abuse where there were many opportunities where she should and could have been asked.

The QA Panel noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published.

Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel