

**Safer Woking**

**Partnership**

**Domestic Homicide Review**

**Executive Summary**

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

Review into the death of Jean
 in December 2019

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**Preface**

The Safer Woking Partnership and the Review Panel wish at the outset to express their deepest sympathy to Jean’s family and friends. This review has been undertaken in order that lessons can be learned.

This review has been undertaken 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 of this incident in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by the Safer Woking Community Safety Partnership on receiving notification of the death of Jean in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

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**Section One – Introduction and agencies participating in the Review**

* 1. This Domestic Homicide Review was undertaken by the Safer Woking Partnership following the murder of one of its residents. That murder took place in December 2019.
	2. The victim in this case will be known as Jean. She was 86 years old at the time of her death. She had been married to her husband, Michael for 59 years. She had three children and several grandchildren. Jean had suffered a severe stroke in June 1991, and she had become more and more disabled over the years, walking with a frame, and finding it difficult to communicate verbally.
	3. She lived at home with Michael and one of her sons. That son, who was 46 years old at the time, was responsible for her murder.
	4. The attack upon Jean happened in the early afternoon in the kitchen of the family home. The perpetrator then threatened to kill his father. His father managed to escape the house and call the police. The perpetrator was arrested at the scene.
	5. Following his arrest, he was deemed unfit to be detained and was ‘sectioned’ under the Mental Health Act. Some months later he was deemed fit enough for interview. He denied the offence, blaming his father. He was charged with murdering his mother and the threats to kill his father.
	6. He continued to plead not guilty at a subsequent trial but was convicted of both the murder and threats. He was sentenced to a term of life imprisonment. He continues to show no remorse.
	7. The Safer Woking Partnership was notified of the murder by the police within days of its occurrence. Thereafter followed a meeting between the Chief Executive of Woking Borough Council and the Community Safety Partnership Chair who considered the recommendation of the earlier meeting and agreed that the criteria had been met and that a review should be held. The Home Office were notified of the decision within one month of that decision.
	8. A Chair and Independent Author were commissioned, and all agencies were asked to secure records and complete an initial scoping exercise. The first DHR Panel meeting took place in June of 2020. This and all future panel meetings were held virtually because of the COVID-19 restrictions in place at the time. As the judicial process had not completed the Review initially progressed in limited scope.
	9. The family were notified of the decision to undertake the review, the fact that it would proceed initially in limited scope and an invitation to participate in it. They were provided with details of specialist support agencies. The family were subsequently full contributors to the Review, and this will be explained later.
	10. The following agencies engaged with and contributed to the Review.
* Ashford and St Peter’s Hospital
* Guildford and Waverley Clinical Commissioning Group
* Surrey and Borders Partnership NHS Foundation Trust
* Surrey County Council – Adult Social Care
* Surrey County Council – Substance Misuse Commissioning
* Surrey Police
* Woking Borough Council
* Your Sanctuary – local domestic abuse specialist support service
	1. The perpetrator’s trial took place in October/November 2020. The Independent Chair, Overview Author and lead officer for the CSP all attended at various key points. Thereafter the review continued to completion.
	2. The Overview Author met with the family during the trial and subsequently the Chair and Overview Author met with Michael, her sister, son, and other family members virtually. The family provided invaluable information to the Review. They were provided with a copy of the Draft Overview Report to read in their own time and made several suggestions. These were all addressed within the final version of the report.
	3. The Independent Chair and Overview Author interviewed the perpetrator in prison after his conviction. He provided minimal information of relevance and he continued to show no remorse.

**Section Two – Agency contact and information learnt from the Review**

2.1 A Domestic Homicide Review is charged with identifying any trail of domestic abuse.

2.2 This case is marked by several factors:

* The lack of visibility by almost any agency of life within the household, even given Jean’s deteriorating health
* Parricide
* The relationship between the perpetrator and his family
* The perpetrator’s mental health and personality
* The perpetrator’s coercion and control
	1. Each of these aspects is discussed fully within the overview report.
	2. The Review is grateful to Jean’s family and friends for the insight into her life. The review has drawn on information shared directly with the review and information gleaned during the murder inquiry.
	3. Jean suffered a severe stroke in 1991, at the time she was in her 50s. Over the coming years, she became less mobile and found it more difficult to communicate. Michael says that she mainly used notes to communicate with people following her stroke. She could not really speak at all, she tried to answer things, but it was difficult to communicate. She would write things and you would eventually understand what she was getting at. Michael also said that she used a walking frame to help her get around. Although it took her a while to get where she was going, she would refuse all offers of help. A few months before her death he bought her a mobility scooter, but it was put in the garage and was very rarely used. Whilst her family thought it would give her a greater level of independence, she did not like it at all as she felt it signified her loss of independence.
	4. **For the review to consider only Jean to be ‘vulnerable’ because of the effects of the stroke would be to miss who Jean *really* was and would be a disservice to her memory**.
	5. Jean is described as a woman who loved life and loved her family. She worked (other than when her children were small) and made every effort to keep in contact with old work colleagues. She had many hobbies. She was an accomplished photographer and, over the years, took many hundreds of photos that she kept in albums and boxes. When Jean gave up work after her stroke, she kept busy by joining a craft group which she was part of for 16 years. She enjoyed painting using watercolours. She also enjoyed her sewing classes and learning to embroider greetings cards. The organiser of the craft group described how Jean had made a particular friend at the group. She described them as ‘being giggly together and having a laugh often at something naughty!’ Jean was very determined but would get frustrated if she could not do something perfectly.

**Section Three – Key issues arising from the Review**

3.1 The review considers the following to have been worthy of particular analysis.

3.2 **Support for the family**

The review has considered whether additional support for Jean and her family might have impacted upon the outcome. It is clear that Jean and Michael were coping well with their situation, Jean was not isolated in the home, and they had a supportive family. Jean was also attending several clubs and groups where there were people who they were able to assess if additional support was needed.

3.3 Jean’s family have confirmed to the review that Jean and Michael were dealing with their situation themselves. Additional aids were purchased when needed. For example, Jean had a stairlift, a bathroom that was adapted to allow her to sit in the shower and a mobility scooter. It would not have occurred to them to ask others for help. It was not recorded on Jean’s GP record that Michael was a carer for her and therefore he was not offered a carer’s assessment, and he certainly would not have seen himself as such.

**The review has considered whether Jean met the threshold for support from statutory agencies and have been assisted in this by a range of organisations. The review is satisfied that there were not opportunities missed to provide additional support to Jean and her family.**

3.4 **Issues post-conviction**

Whilst the review has identified several issues relating to this perpetrator’s behaviour, it is the aftermath of the murder and the conclusion of the criminal justice process that continues to cause the family significant difficulty. In particular, the control that a perpetrator can continue to exert from prison, after conviction. In this case it relates to his property that he simply refuses to engage with over its disposal. We are aware that Victim Support are assisting Michael with this, but it is a visual reminder, every day, of the awful events that befell this family.

**The review has made a national recommendation in relation to this general issue.**

**Section Four – Lessons Identified**

4.1 The review has identified the ongoing trauma that victims of domestic homicide experience when the perpetrator continues to control their life and property from prison.

**Section Five – Recommendations**

* 1. **Safer Woking Partnership**
		1. That the Safer Woking Partnership holds a series of sessions for practitioners across partner agencies that raises awareness of coercive and controlling behaviour and economic abuse, particularly drawing attention to how it occurs in families.
		2. That TALK, the organisation providing the drop-in sessions attended by Jean, is specifically invited to be part of one of these sessions.
		3. That the Safer Woking Partnership runs a public campaign that raises awareness of coercive and controlling behaviour and economic abuse, particularly drawing attention to how it occurs in families.

5.2 **Ministry of Justice**

5.2.1 That the Ministry of Justice clarifies the legal position to allow victims of crimes of this nature to be able to dispose of property.

**Section Six - Conclusions**

6.1 In many ways there is much about this case that remains something of a tragic mystery. The murder and horrific mutilation of an elderly lady by her own son without any prior indication of any issues between them is, at first glance, in many ways unfathomable. However, the review has demonstrated a gradual onset of coercive and controlling behaviour by the perpetrator within his family.

6.2 During the police investigation, his trial and subsequent interview in prison as part of this review, this perpetrator has not indicated any remorse whatsoever and has sought to shift the blame entirely on to others.

6.3 The lack of knowledge of the family, by any of the statutory agencies who provide support in the local area is a testament to the family’s desire to ‘get on with life’. This is despite the significant disabilities suffered by the victim because of a cruel and savage stroke.

6.4 The family have reconciled the actions of this perpetrator upon a psychotic episode. The jury found him guilty of his mother’s murder, rejecting his assertions that he was not responsible. He still refuses to accept responsibility for his actions despite the overwhelming evidence upon which he was convicted.

6.5 This review has drawn heavily upon the perpetrator’s psychological state at the time in an effort to understand what happened and learn from it. The existing research upon parricide cases is set out within this report and those who continue studies in this area will no doubt add this case to that body of evidence.