Domestic Homicide Review 2

Part I

Executive Summary

1. **The Review Process**

1.1 This summary outlines the process by the Tower Hamlets Domestic Homicide Review Panel in reviewing the murder of GM (henceforward referred to by the pseudonym GINA) in March 2012 by her brother, TM (henceforward referred to by the pseudonym TERRY).

1.2 The key purpose for undertaking any DHR is to assess what, if any, lessons may be drawn from a particular case. Although neither party to this homicide was known to have come to notice in a DV context, the Tower Hamlets Community Safety Board decided that a review should be conducted to determine whether this lack of agency awareness might, of itself, indicate lessons for the future.

1.3 The review was formally commissioned on 14th August 2012. Prior to the trial of TERRY, all agencies were asked to secure whatever material they might have to contribute to the review and, where appropriate, commence their own Individual Management Reviews (IMR). TERRY pleaded guilty to a charge of manslaughter but not guilty to murder. He was convicted of murder. In sentencing him to life imprisonment, Mr. Justice Fulford recommended that he serve a minimum term of 20 years, describing the offence as an "utterly cold-blooded and determined killing ..... made worse by attempts to conceal the body and point the finger of blame at others". The trial concluded on 30th January 2013, at which point work commenced to bring together all available material to complete the review and produce this report. The Review Panel convened on 9th July 2013 to consider the first draft of the report. The panel requested additional enquiries which entailed seeking an extension of the normal six month time limit for completion of reviews. An extension was granted by the Tower Hamlets Community Safety Board on 10th July 2013.

1.4 **The Review Panel consisted of the following members:**

- Mr. John Biggs – Member of the London Assembly
- Ms. Emily Fieran-Reed – Lead Officer, Domestic Violence Forum, London Borough of Tower Hamlets
- Ms. Kate Gilbert – Assistant Chief Officer, East London Probation Trust
- Ms. Maddi Joshi – Senior Service Delivery Manager, Victim Support (provider of IDVA services in Tower Hamlets)
- Ms. Margaret O'Donovan – NHS Primary Care Trust
- Mr. John Rutherford – Interim Service Head of Adult Services, London Borough of Tower Hamlets

- Chief Superintendent David Stringer – Metropolitan Police (Borough Commander for Tower Hamlets)
- Mr. Jonathan Warren – Director of Nursing, NHS East London Foundation Trust
- Commander Stephen Watson – Metropolitan Police (Territorial Commander for East London)
- Detective Inspector Natalie Cowland – Metropolitan Police, SC&O 21(2)

1.5 Mr. Stephen Roberts, QPM, MA, was appointed by the Tower Hamlets Community Safety Partnership Board as Independent Chair of the Review Panel and Report Author. Mr. Roberts is a former Deputy Assistant Commissioner of Police, now working as a private consultant, with extensive experience of partnership working at borough and pan-London level. He is a former Director of Professional Standards and Director of Training & Development for the Metropolitan Police. He is entirely independent of the London Borough of Tower Hamlets Community Safety Partnership. He has successfully chaired and authored a previous domestic homicide review for the Partnership.

1.6 **The review was guided by the following terms of reference:**

To establish what lessons may be learned from the case regarding ways in which local professionals and agencies worked individually and collectively to safeguard victims.

To determine how those lessons may be acted upon.

To identify what may be expected to change and within what timescales.

To assess whether the relevant agencies have appropriate and sufficiently robust procedures and protocols in place and the extent to which they are understood and adhered to by their staff.

To improve service responses including, where necessary, changes to policies, procedures and protocols.

To enhance the overall effectiveness of efforts to reduce domestic violence and its impact on victims through improved inter and intra agency working.

1.7 The following agencies were asked to participate in the review process, conducting and reporting Individual Management Reports (IMR) if appropriate:

- The Metropolitan Police
- The London Borough of Tower Hamlets (Housing Department, Adult Social Services & MARAC)
- The Probation Trust
- East London NHS Foundation Trust (Mental Health & Substance Abuse Unit
- City & Hackney Primary Care Trust
- Victim Support (provider of IDVA services)

1.8 Each agency was asked to provide a chronological account of its contact with the victim and/or suspect and an IMR where appropriate. In fact, only the Metropolitan Police

submitted an IMR. All other agencies advised that there had been either no contact with GINA or TERRY or none of significance to this review. For this reason, the Overview Report of the DHR contains no consolidated chronology.

1.9 Prior to the establishment of this DHR, TERRY was charged with murder. The MPS granted partial access to the evidence gathered by its homicide investigation team at various stages of the review. This enabled a more detailed picture to emerge of the relationships and domestic arrangements in the household than might otherwise have been possible.

1.10 The MPS also provided a copy of it's Critical Incident Review. The primary focus of this review was to assess the adequacy of MPS action from receipt of the missing person report in relation to GINA until the identification of her remains.

1.11 In a further effort to identify the underlying causes of the tragedy, the Chair/Author of this report attended the trial of TERRY at the Central Criminal Court. TERRY gave evidence in his own defence but called no witnesses.

1.12 At the conclusion of the trial a written request was made to the judge for a copy of his summing up speech to the jury. The request was declined. This was not a serious impediment to the review due to the attendance of the Chair/Author for the entire trial.

1.13 A request was also made to the MPS to release the formal written witness statements of all prosecution witnesses who had known GINA or TERRY personally. This enabled personal interviews to be conducted by the Independent Chair with various close friends, neighbours and relatives of both TERRY and GINA, including TERRY's female partner at the time of the homicide and family friends who had known both siblings almost from birth. Unfortunately, neither of TERRY/GINA's parents was available for interview: their father had in any case been separated from them for many years and their mother was too unwell to cope with an interview.

1.14 Despite the fact that the family was essentially unknown to the agencies before the homicide, an opportunity was identified to extract value from the review process. The information from the MPS IMR, the trial of TERRY and from the personal interviews with friends and relatives of GINA were collated into a draft version of this Overview Report, which was then circulated to all agencies with a request to consider two questions:

Are there any steps that each agency might take to increase the chances that a domestic situation such as that in the M household might come to notice?

Had this information been known, what if any action might have been taken to avert the tragedy?

1.15 In response to these questions, the NHS East London Foundation Trust provided additional material to the review. This led to a fact-finding interview with the lead manager of the Community Drugs Team to explore what services it might have provided to TERRY had he been referred or applied directly for help with his heavy cannabis consumption habit.

1.16 **The Review Panel meeting on 22nd July 2013 asked that additional enquiries be made:**

Renewed (but ultimately unsuccessful) efforts to interview GINA's mother.

An attempt by the Independent Chair to interview TERRY himself (by now imprisoned at HMP Belmarsh).

Access to psychiatric reports presumed to have been prepared in respect of TERRY in preparation for his trial.

Access to the NHS records of GINA and TERRY to verify the fact that there was no recorded history of GINA seeking help for unexplained injuries or any disclosure by either GINA or TERRY indicating domestic violence between the siblings.

1.17 Gaining access to the NHS records for GINA and TERRY, though necessary, entailed a lengthy delay. In the event, examination of both sets of records revealed no trace of any indication whatever that domestic abuse was a feature of the relationship between the brother and sister. The delays are a strong indicator of the absence within NHS England of an established and widely understood policy on the release of records for DHR purposes.

1.18 Enquiries with HM Prison Service, the Probation Trust and Care UK Ltd (the health services provider for HMP Belmarsh) revealed that no psychiatric assessment of TERRY had been requested or made prior to his trial.

1.19 Despite the best efforts of an Assistant Governor and TERRY's Offender Supervisor and Probation Officer, TERRY declined to be interviewed about his offence. Apparently his reason for declining an interview was that he himself still did not understand what had happened or why it had happened.

1.20 At the conclusion of this review efforts to seek views on the final draft of the report from members of GINA's immediate family were unsuccessful. GINA's mother had died in December 2013 and her older brother and father declined contact with the review from the start. Recent enquiries indicated they had also disengaged from Victim Support.

1.21 The Overview and Executive Summary reports were ultimately agreed by the Review Panel and Community Safety Partnership Board on 8th January 2014.

2. Key Findings

2.1 No agency had contact with either TERRY or GINA in relation to domestic violence between the two siblings.

2.2 In interviews, friends, relatives and long-standing neighbours (some of whom had known the siblings since birth), whilst acknowledging their fiery temperaments, were all at pains to describe TERRY and GINA as close and loving siblings, whose occasional arguments were simply those of ordinary brothers and sisters. Even after the revelation of the detailed means by which TERRY had dismembered and disposed of GINA's body had become known

at the trial, not a single person interviewed suggested that they had been aware of any indication that TERRY might have been capable of such acts, let alone likely to commit them.

2.3 A somewhat different view of the domestic relationships at the M family home emerged during the police investigation into the homicide. TERRY and GINA's parents had divorced many years before and their father (TERRY senior) had very little contact with his former wife or their children. Evidence at the trial revealed that GINA and her mother had told TERRY senior that on three occasions in 2011, TERRY had threatened them. Apparently on two of those occasions, as a result of GINA complaining to TERRY about his cannabis smoking, he had assaulted her in the house. On both occasions, TERRY had grabbed GINA around the neck and held her down, screaming and swearing at her. On both occasions she had been able to push him away. Apparently on another occasion, during an argument, TERRY had stood up, run across to his mother, thrusting his face into hers in an intimidating manner, shouting and screaming at her for telling him what to do. TERRY's father also revealed that when he had gone to the M family home, TERRY had also threatened him. None of these incidents were reported to the police or any other agency or indeed to friends or other family members.

2.4 There is ample evidence that TERRY was a heavy user of "skunk" cannabis and that his drug use had become a source of tension with his mother and GINA. At his trial, TERRY gave evidence that by February/March 2012 he was smoking about an ounce of "skunk" a day.

2.5 Had TERRY regarded his cannabis habit as problematic he could have been referred or referred himself to the Tower Hamlets Community Drugs Team (CDT). The services of the CDT are well-advertised across the borough and via the internet. The service is also promoted via almost all GP practices in the borough, including that used by TERRY. The CDT currently has approximately 600 clients using a variety of drugs but principally heroin and cocaine/crack cocaine. As such problematic cannabis use would be regarded as a relatively low priority. All workers are, however, trained in risk assessment and use of the DASH proforma which is use across all agencies in Tower Hamlets. In the event that a client is regarded as presenting a risk in relation to domestic violence, s/he will be referred for the standard MARAC (Multi Agency Risk Assessment Conference) process.

2.6 Additional enquiries at the CDT failed to reveal any evidence that TERRY had ever sought help with his cannabis habit.

2.7 Interviews with GINA's friends, relatives and neighbours indicate that she was a poplar, outgoing highly sociable young woman with an extensive network of friends in whom she felt able to confide. These interviews as well as the results of the police investigation indicate that though GINA was upset, tearful and irritated by her brother's behaviour, she showed no signs that she felt in fear of violence from him.

3. Conclusions & Recommendations

3.1 The reluctant conclusion of this review must be that the tragedy of GINA's murder was not realistically foreseeable or preventable. It must be acknowledged that this is a somewhat uncomfortable conclusion when juxtaposed against the murder and details of body dismemberment and disposal. The phenomenon of outcome/hindsight bias is relevant to disinterested readers of this report. Readers may all too easily fall into the trap of believing that such a tragic event and grotesque aftermath must have been preceded by some indications or warning signs and that those signs could/should have been acted upon to avert the tragedy. Neither the police homicide investigation, nor this review have uncovered any such prior indications. There is no indication that any such signs were perceived even by the victim herself or her relatives or closest friends. In these circumstances it is unrealistic to conclude that a professional from outside the intimate circle of close friends and relatives would have come to a different conclusion. It is therefore the reluctant conclusion of the review that, notwithstanding the tragic outcome, the agencies did not and could not know of the severity of tensions between TERRY and GINA.

3.2 It is possible that knowledge amongst local drug users that the CDT concentrated it's resources on cocaine and opiate addiction may in some way have inhibited TERRY's purported desire to seek assistance with his cannabis habit. The opportunity therefore exists to enhance the provision for support and treatment of those with a wider range of substance abuse problems.

3.3 **Four recommendations emerge from this review:**

Recommendation 1 - that LBTH Community Safety Partnership assess the extent to which current DV arrangements and awareness campaigns address violence between siblings and inter-generational conflicts. If appropriate, communications strategies and resources should be re-targeted to ensure proportionality between these types of case and those between intimate partners, which are more prevalent.

Recommendation 2 – that LBTH re-procure it's contract(s) for substance misuse treatment services with a view to simplified referral processes, and enhanced psychosocial interventions for non-opiate users, including extensive publicity and an ongoing communications strategy embracing the full range of its stakeholders.

Recommendation 3 – that all agencies participating in the LBTH Drugs & Alcohol Action Team (DAAT) ensure that appropriate staff receive DA/DV training, and the training supplied by Public Health England regarding services to non-opiate users.

Recommendation 4 - that NHS England develops and implements clear policy and procedures to ensure that records and/or IMR are provided promptly to support DHR processes.

An Action Plan for implementation of the recommendations is attached to the Overview Report at Appendix A

Stephen Roberts, QPM, MA(Cantab)

Independent Chair & Report AuthorText