

Safer Buckinghamshire Partnership

(Formerly Aylesbury Vale Community Safety Partnership)

Domestic Homicide Review August 2019 - following the death of Philip, who died in March 2018

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A message to the families

The Panel would like to express their condolences to the families of Philip, and particularly to the four children of Philip and Eva, who now must re-start their lives without their parents. This has been a sad case to review and the Panel wish the children the very best future as they move forward with their lives.

The Domestic Homicide Review process

- 1) This summary outlines the process undertaken by Aylesbury Vale Community Safety Partnership domestic homicide review panel in reviewing the death of Philip, a white British man aged 55 years, and was a resident in their area.
- 2) The following pseudonyms have been in used in this review for the victim and other parties to protect their identities and those of their family members:
 - The perpetrator is Eva, a female aged 54 and whose ethnicity is White European.
 - The adult and school aged children of Philip and Eva, white British ethnicity
 - Andrew – elder brother of Philip
 - John – Cousin of Eva
- 3) Criminal proceedings were completed on 20th March 2019 and the perpetrator was found guilty of murder, with the sentence being life, serving a minimum of 16 years.
- 4) The process began with the Community Safety Partnership in April 2018 agreeing to undertake a domestic homicide. All agencies that potentially had contact with Philip prior to the point of death, were contacted and asked to confirm whether they were involved with him.
- 5) 7 of the 15 agencies contacted confirmed contact with the victim; perpetrator and children involved and were asked to secure their files.

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Contributors to the review process

- 6) The agencies engaging in the Review are as follows:

Contributors from Thames Valley Police

- Thames Valley Police – provided an initial IMR which was later replaced by a more detailed Review following the conclusion of the case at the request of the Panel.

[Contributors from Buckinghamshire Council](#)

- Buckinghamshire Children’s Social Care - provided an IMR which covered First Response and the Multi Agency Safeguarding Hub (MASH)
- Buckinghamshire County Council Education Service - provided a report with recommendations to improve the service and an explanation of Home Education and the legal aspects relating to this.

[Contributors from the NHS](#)

- Buckinghamshire Clinical Commissioning Group (General Practitioner - GP) – provided an IMR
- South Central Ambulance Service – provided an IMR
- Buckinghamshire Healthcare Trust - provided a short note about information they held that did not pertain to the period of the review
- Oxfordshire NHS Foundation Trust (mental health service provider for Buckinghamshire) – confirmed they had not engagement with family

7) The subjects of the Review were not known to any other services.

8) All the information and reports provided were given by staff who were not involved with the subjects of the review or have any direct management of staff who had previous links with the subjects.

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[The review panel members](#)

9. The following people attended and supported the Review process. In addition to the three meetings that took place, there were numerous exchanges of emails and the sharing of the draft report, action plan and recommendations, between the relevant agencies.

DHR Chair

- Gillian Stimpson - attended all meetings

Community Safety Partnership

- Will Rysdale- Chair - Community Safety Partnership - Attended all meetings
- Chris Oliver, Community Safety Advisor – AVDC Community Safety – Attended two meetings

NHS Panel members

- Tony Heselton - Head of Safeguarding and Prevent – SCAS – Attended one meeting
- Nuala Waide - Associate Director for Adult and Children's Safeguarding Buckinghamshire Healthcare Trust – Attended one meeting
- Krista Brewer - Safeguarding Adult Lead - Bucks Clinical Commissioning Group – Attended two meetings
- Mary Buckman - Associate Director of Social Care - Oxford Health Trust – Attended two meetings
- Gillian Attree - Designated Nurse Safeguarding Children and Looked After Children - Buckinghamshire Clinical Commissioning Group – Attended one meeting

Probation Service panel members

- Debbie Johnson - Senior Operational Support Manager - National Probation Service – Attended two meetings
- Linda Ricks – Senior Probation Officer - National Probation Service – Attended one meeting

Thames Valley Police panel members

- Carl Wilson – Acting Detective Inspector - Thames Valley Police Domestic Abuse Investigation Unit – Attended two meetings

- Claire Knibb – Detective Chief Inspector – Thames Valley Police – Attended one meeting
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[Buckinghamshire Council Panel members](#)

- Amanda Andrews - Head of Service - First Response, MASH & Assessment Teams - Buckinghamshire County Council Children’s Services – Attended two meetings
- Julie Murray – Head of Service, Safeguarding Adults, Deprivation of Liberty Safeguards - Buckinghamshire County Council Adult Safeguarding – Attended all meetings
- Viv Trundell - Educational Entitlement Manager - Bucks CC Elective Home Education – Attended two meetings
- Julie Davies - Head of Quality, Standards and Performance - Buckinghamshire County Council Children’s Services – Attended two meetings

Charitable and community panel members

- Denise – Head of Service - Aylesbury Women’s Aid – Attended two meetings

10.No one engaged with the Panel or the IMRs has had any direct link with Philip or managed any staff who have been engaging with Philip.

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[Author of the overview report](#)

11.The Domestic Homicide Review has been chaired by Gillian Stimpson of Lime Green Consultancy Service Ltd. Gillian has been the Director of the Company since 2015 and has been undertaking Domestic Homicide Reviews and chaired two Serious Case Reviews, one for a baby death and one into child sexual exploitation.

12. Gillian has had previous experience as a Police Officer in the Metropolitan Police from 1978 to 1987 and as Community Safety Manager for Wycombe District Council, from 1993 to June 2015. Gillian currently has no connection to the Community Safety Partnership other than in the undertaking of the Domestic Homicide Review.
13. In 2013 Gillian successfully undertook the Domestic Homicide Chair Certificate, a Home Office funded 5-day training course delivered by AVA (Against Violence and Abuse) accredited by the Open College Network (OCN). Gillian continues to undertake professional development and attended a day's training on the new Domestic Homicide Review Guidance. In addition, Gillian has attended learning events which have included keynote speakers covering specialist support for families, modern day slavery and intimate partner homicide. Lately Gillian has also attended an AAFDA Information and networking event.
14. Gillian has undertaken 4 completed Reviews and is currently involved with 2 further Domestic Homicide Reviews as the Panel Chair.

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Terms of Reference for the review

The purpose of a DHR is to:

- a) 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;
- b) 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;
- c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

15. The Review will cover a period of 1 year prior to the homicide but those participating in the Review are to consider contacts and engagement with the victim and perpetrator prior to this and if there is information that would be relevant to the review, that should also be included.

Specific issues to address

16. Was there evidence of a risk of serious harm to the victim or the perpetrator that was not recognised or identified by the agencies in contact with them? Was there any evidence which might have raised a homicide concern for the victim or the perpetrator?

- Family, Friends, neighbours, and work colleagues
 - a) Whether family or friends want to participate in the review. If so, ascertain whether they were aware of any circumstances which might have led to the homicide of the victim?
 - b) Whether, in relation to the family, friends, work colleagues and neighbours it is known that there were or could have been any barriers experienced in reporting abuse.
 - c) Is there any evidence of controlling or coercive behaviour; being experienced by the victim or the perpetrator? If so, did the victim or perpetrator have appropriate opportunities to report concerns.
 - d) What, if any, are the legal requirements around the notification to authorities in respect of home education by parents and schools and, if there are legal requirements, were they followed by the family and Buckinghamshire County Council – Education Department in respect to the children in this case?
 - e) How have these requirements changed over the years since the children were first removed from school in 2006? What does the Buckinghamshire picture look like in respect to the number of children recorded in Home Education and is this likely to be a correct number? What is the general process when a notification to Buckinghamshire County Council is received in respect to a child receiving a home education, including if these processes exceed the national legal requirements?

- f) What might the impact of the way the family lived in social isolation have had on the children in the past and of how they move forward?
- g) Did the family have any religious beliefs or belong or follow any cult, and if so, did they attend meetings or services, and can this have attributed to their lifestyle choice?
- h) Where any agencies had a connection or link with the family, can it be shown that those involved displayed evidence of professional curiosity particularly in respect to their choice about how they lived and raised the children?
- i) Was there any implication in respect to the homicide which might be attributed to the family having no access to technology?

17. Could improvement in any of the following have led to a different outcome for Philip considering:

- **Communication and information-sharing between services.**
 - a) Was information or were there any opportunities available which might have identified that there was a serious risk of harm the victim, but that was not shared with other agencies?
 - b) In circumstances where information or opportunities were available and shared, were they acted upon in accordance with the agencies' recognised best professional practice?
 - c) Communication within services – was relevant information about the victim shared and acted upon appropriately within agencies?
 - d) Is suitable advice and information available and accessible, including the availability of specialist services, for those who may be at risk of experiencing domestic abuse?

18. Does the homicide appear to have any implications or reputational issues for any of the agencies or professionals?

19. Does the homicide suggest that national or local procedures or protocols may need to be changed or are not adequately followed or understood?

20. Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

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Summary chronology

21. The family had lived since November 2014 in a detached house, on an estate. It was privately owned by the family with no mortgage.
22. Neither Philip nor Eva worked at the time of the death. Philip used to work in schools, but he hadn't worked since 2015. It is believed they lived off their savings (mainly through inheritance.) Eva was a stay at home mother and acted as the children's teacher, although she had trained as a midwife previously.
23. The eldest children attended a primary school. They then attended a secondary school studying for GCSEs in academic years 11/13. The younger children were always home schooled and not known to education services.
24. The family appears to have withdrawn from the community and their extended family. Indeed, Philip has a brother in Scotland who tried to contact him when their mother was ill. She subsequently died but Philip nor the rest of the family replied to any contact. Eva has a larger dispersed family, but she stopped connecting with them. It was reported by a branch of the family in Canada, (a cousin) who came over in 2017, that they arrived and tried to visit the family, however they were refused entry at the door.
25. The house, at the time of the police entering the property, was cluttered with belongings but there were also areas, such as the children's rooms that were tidier and more seemed well used. The children each had a room in the house which are described as being full of traditional crafts, such as knitting and woodwork. Whilst not identified as hoarders, the family did not appear to throw anything out. The downstairs living space and master bedroom were more cluttered. The kitchen and dining room were used as would normally be expected. Although cluttered the house did appear that it was cleaned regularly, and it wasn't disordered. The children appeared to have been brought up in an environment which seemed to be a rather old traditional style. There was little technology in the house as there were no phones, tv, computers etc., but there was a radio. The children have been brought up in a conditioned environment which could be viewed as a very old traditional style.

26. The children did not mix with other children. The family went out to shop but lived very frugally. They owned two cars. Other trips out appear to have been for educational purposes.

27. On the day of Philip's death, it appears he had been unwell and was struggling to breathe and was in the bathroom. He did not like seeking medical attention. He was a sufferer of asthma which was diagnosed in 2005 when he was briefly admitted to hospital after an attack, but there is no further evidence of him receiving any treatment or medication for the condition.

28. The family were trying to home treat him using items such as Vicks VapoRub¹. He was in the bathroom on the floor when the ambulance crew arrived. It is claimed that he said he did not want to seek medical assistance. It is reported that he died on the previous day at 7pm, however, Eva did not seek any medical assistance for Philip that day. Her first contact was going to the neighbour's house to ask them to call for an ambulance at 7.30am the following day. Philip and Eva did not have a phone, hence the request was made to the neighbour to call. Eva called for an Ambulance. South Central Ambulance Service (SCAS) notified the police due to signs of injury to Philip's head. Eva was arrested soon after police attended as there were obvious injuries to Philip.

29. It seems that at some point after 2015, when Philip stopped working and bought the property, that they currently lived in their lifestyle changed. The Panel has been unable to establish what might have been the catalyst for this. It is possible that Philip was regularly abused by Eva, who, it is believed used to hit him over the head and back with a rolling pin and a hairbrush. A neighbour suggested that Philip used to be a portly man who, since 2015, had become about half his original size and appeared to be barely able to walk.

30. The family had lived in the town for many years and the children were born in the town.

31. There is very limited engagement with the family, indeed the only statutory agency involvements were in June 2017 when the Police were called by a

¹ Vicks VapoRub is an ointment which is used to relieve nasal catarrh (inflammation of mucous membranes in the nose and throat), congestion (a blocked nose), sore throat and coughs due to colds.

neighbour of the family after a visiting cousin of Eva's, who currently lives in Canada, had been so concerned about the lack of contact with the family they made a trip to visit them. However, the family member was refused entry at the doorstep. This resulted in the relative being very concerned about the family and so he attempted to contact the local Children's Safeguarding Board to find out how to report his concerns. The neighbours called the Police to see if they could check on their welfare. This proved difficult but after a few days an officer did manage to speak to Eva and the children in their garage, where she saw them on a visit to try and speak to the family. Whilst Eva went to get Philip the officer spoke with the children. The family suggested they did not answer the door to the family member as they did not want to speak with them. There were no concerns raised by either Philip or Eva with the officer about their welfare, but the officer was concerned about the emotional well-being of the children because of the family's lifestyle choice and so made a safeguarding referral.

32. This referral resulted in enquiries being made by the Multi Agency Safeguarding Hub (MASH) which established the family were not known to any universal agencies including a GP or schools. Despite this the case was assessed by the Team Leader as there being no role for social care at this stage and a letter was sent to the family to this effect.
33. The only engagement the Ambulance Service had was following the call from Eva when she rang for an ambulance, following Philip's death.
34. There had been no engagement with any Education services or schools since the eldest child left education, following attendance at a secondary school. For the two youngest children there was no engagement with state education at all.
35. None of the family had been seen by their GP since 2005. Letters had been sent to Philip about an NHS check, screening for bowel cancer and having a flu jab, but these offers were never taken up.

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[Key issues and conclusions arising from the review](#)

36. This Review has identified that this is an unusual set of circumstances which has meant that a family is almost invisible to the main statutory and

universal services, including a GP. A family that had been functioning in a more conventional style for some years and then suddenly, for reasons we are unable to establish, then chose to remove themselves from society. They removed the elder children from school and did not enter the younger children into any school; no longer sought medical assistance, although clearly it may have helped Philip who seemed to have several health problems. They chose to no longer have any modern technology, except for a radio. Where they had in the past had a telephone, they no longer used one.

37. The withdrawal of the children from education and the non-attendance at any educational establishment for the younger children meant that they had become virtually invisible to the education services.
38. They stopped contact with their families, indeed on a couple of occasions they were notified of deaths in their families, but they did not acknowledge these notifications. One of the notifications included the death of Philip's mother. Their extended families were concerned about why they no longer chose to communicate with them and ultimately the Canadian cousin of Eva travelled to the UK to try and establish if the family were well.
39. When an alarm was raised by Thames Valley Police, following the call to police by a neighbour, the response from Buckinghamshire County Council, First Response and MASH should have been more curious. This was perhaps the only opportunity for an intervention to have been made and because it was not sufficiently investigated or any degree of professional curiosity applied, it was closed with no further action.
40. The Canadian cousin of Eva sent a lengthy email of concern to the First Response email address, but this was never received by the Service as an incorrect address was used. It is very unfortunate that this occurred as, had the Service received the email, even if the family did not respond to a letter sent by the Service, undoubtedly a visit to the home would have been made.
41. The long-term and consistent physical abuse on Philip by Eva led to a long and painful period of possibly 3 years where Philip received significant injuries. He did not present to health services and so was not treated by any medical service for these injuries. Ultimately this led to his collapse in the bathroom and, even at this time, no medical assistance was sought for him

until the following day, when an ambulance was eventually called, by which time he had died.

42. This is a very sad case which has left the young people without their parents and now, not only having to cope with this loss, but they are also having to re-build their lives. The feedback from the Canadian cousin is that he has been very impressed with the work that has been provided by Social Care following this sad incident and that he has now been able to re-establish links with the children and been able to visit with them and take them out.

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Lessons to be learned

43. As most services did not have any involvement with the family, through the family's choice there are not many lessons to learn about the case, except for Buckinghamshire County Council Social Care – MASH and First Response; Education Service and Thames Valley Police.
44. Buckinghamshire County Council Social Care – MASH and First Response - a visit to the family should have been arranged given that no universal agencies (GP and school) had seen the family for some time, and the family had refused to open the door to another family member. In addition, there was no point in trying to contact the family by phone as the police had already reported that did not have access to a phone.
45. The home schooling of children and the absence of contact with the family GP should have triggered consideration being given what might have been going on in the home and what life might be like for the children. A visit to the home to see the children, consider if and why Eva may be suffering any level of paranoia (as asserted in the Police referral) would have offered a window into family life and an opportunity to establish if any support was needed and if the children were or likely to be at risk of harm or significant harm.
46. An improvement plan in place has seen changes in MASH which now ensure there is a greater consistency in compliance with expected practice standards. Alongside this, the service has undertaken work to improve the sharing of learning from local and national serious case reviews which have

relevant lessons in this case about the potential safeguarding risks where children are home educated.

47. Thames Valley Police - followed the correct procedures and raised a safeguarding concern with Buckinghamshire County Council's Children's Services.
48. The standard practice in MASH is to provide feedback to the referring agency. The revisions to the statutory safeguarding guidance (Working Together 2018) include that referring agencies should take responsibility to seek feedback if they do not receive this direct from Children's Social Care.
49. This means that it becomes the enquiring agencies' responsibility to enquire about a referral should they need to, and it would not be the receiving agency's responsibility to report back. In this case the cousin from Canada reported a concern but had not been able to establish if the concern was received or indeed acted upon. It was unfortunate that the concerns reported by the cousin were not in fact received by Social Care as an incorrect email address was used. The cousin states that he did not receive an 'Undelivered' message, following the incorrect email address being used. It is appreciated that in a case like this, the person reporting will not be advised of the progress but an acknowledgment without any case specifics being shared seems to be reasonable and reassuring to the concerned person.
50. Buckinghamshire County Council Education Service - had developed systems where reports are run from a database before this case was highlighted. These reports identify any young people where a school base has been closed as the young person is going to be Elective Home Educated but the school have not followed the correct procedure of completing an Elective Home Education Form. Retrospective reports have not been developed.
51. There continues to be a need to ensure that staff and schools are aware of their responsibilities for Elective Home Education Guidance and procedures.
52. Further work is needed on the reports to ensure they are analysed in a timely manner to identify any young people who are not on a registered school base or an Elective Home Education base. This will include reports to include children on the data base for whose education base was closed before they become statutory school age.

53. The Service will also devise an external training programme to ensure all partner agencies are aware of Elective Home Education guidance and inform the Local Authority if they are made aware a child is being home educated.

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Recommendations

Recommendation for Buckinghamshire Children's Social Care

Processes in MASH and First Response will be reviewed by the Head of Service to ensure staff have due regard to the potential risks that home schooling and lack of engagement with universal services may have on the safety and welfare of children.

Panel Recommendation 1 - National

The Home Office reviews the existing Domestic Homicide Review Guidance (2016) particularly the current suggested guidance for the timeframes to complete a homicide review. New guidance should also give more specific guidance to Police Services and other key agencies about the completion of IMRs to ensure they are completed fully from the outset which would assist in speeding up the Review process.

Panel Recommendation 2 - National

The Department for Education, as a minimum, implement changes to the Elective Home Education guidance following their Children not in Education consultation, which places a duty on parents to register their child with their Local Authority when home educating

Panel Recommendation 3 - National

The Elective Home Education guidance following their Children not in Education consultation, should add giving Local Authorities the right to see the child and their home environment to further safeguard children.

Panel Recommendation 4 - Local

The Buckinghamshire Domestic Abuse Strategy Group undertakes public awareness raising about coercive and controlling behaviour. As a minimum there should be an action appended to the current action plan which lays out a publicity campaign around coercive control using existing media platforms.

Panel Recommendation 5 - Local

The Buckinghamshire Domestic Abuse Strategy Group ensures that any future professionals' training in respect to coercive and controlling behaviour includes awareness raising and recognition of the impacts that there might be on the children who live with a controlling parent or parents.

Recommendations Education Service - BES

Recommendation 1 - BES

Continue to ensure schools and staff are fully informed of Elective Home Education Guidance and procedures (Schools Web is to be kept up to date). Regular bulletin article reminding schools of their statutory responsibility

Recommendation 2 - BES

Reports are analysed in a timely manner to identify any young people for whom we do not have a registered school base or an Elective Home Education base. Reports to include children on the data base for whose education base was closed before they become statutory school age.

Recommendation 3 - BES

Devise an external training programme to ensure all partner agencies are aware of Elective Home Education guidance and inform the Local Authority if they are made aware a child is being home educated.

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Glossary of acronyms

AAFDA	Advocacy After Fatal Domestic Abuse
AVA	Against Violence and Abuse
BCC	Buckinghamshire County Council
BES	Buckinghamshire Education Service
BHT	Buckinghamshire Healthcare NHS Trust
CCG	Clinical Commissioning Group

DHR	Domestic Homicide Review
ES	Education Service
GCSE	General Certificate of Secondary Education
GP	General Practitioner
IMR	Individual Management Review
MASH	Multi Agency Safeguarding Hub
NHS	National Health Service
OCN	Open College Network
SCAS	South Central Ambulance Service NHS Trust
TVP	Thames Valley Police

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