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Oliver Nelson
Epsom and Ewell Community Safety Partnership
Epsom & Ewell Borough Council
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30th September 2024

Dear Oliver,

Thank you for submitting the Domestic Homicide Review (DHR) report (Emma, Lettie & George) for Epsom & Ewell Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 14th August 2024. I apologise for the delay in responding to you.

The QA Panel felt that this was a sensitive and compassionately written report. The opening tribute is a thoughtful, moving and detailed account of the victims' lives, which humanises them and keeps them central to the review. The involvement of family, friends and work colleagues throughout the review is powerful in portraying the victims' relationships and experiences and providing insight into the difficulties Emma was facing.

The report includes some relevant and probing lines of inquiry; for example, the effectiveness of the shotgun licencing process and analysis around officers recognising coercive and controlling behaviour. There is also consideration of the barriers in reporting abuse by the victim and her family and friends. The report showed an understanding of the dynamics of domestic abuse and coercive control. In particular, the commentary and supporting research on the elevated risk facing domestic abuse victims leaving an abusive relationship.

The panel commended the use of research more generally, noting the well-evidenced comments and findings and useful references to research on other cases of familicide. The integrated chronology provides a useful context with a clear multiagency picture and links between agency contacts. The report also makes good use of the information from the police witness statements to gain an understanding of the relationship between the victim and perpetrator. The conclusions were well-considered with useful, clearly drawn-out recommendations.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- The QA Panel felt that the contribution in the tributes section from Adult B's father would be better placed in another part of the report.

- The report emphasises the importance of sharing the findings of this DHR with the local Surrey Safeguarding Children's Partnership, but there is no further information on this action and whether it happened. This action should also be included in the dissemination section of the report which has not been completed.

- There is no information on the time-period covered by the review, and there should be more information regarding the decision-making process behind the decision to hold the DHR and which agencies/partners were involved.

- There is no equality and diversity section. It is important to consider the specific protected characteristics of the victims and perpetrator and how these relate to domestic abuse. Where equalities were mentioned, the QA Panel felt it flipped between the victims and Adult B, when the review should focus on the victims.

- Paragraph H on page 5 mentions delays due to the Home Office Quality Assurance Panel were a significant issue. This is inaccurate as the DHR had not been submitted to the Home Office at that time.

- The names used in the report should be set out earlier than in section 3.4.

- Consideration of the eight-stage homicide timeline should be in the Analysis section rather than Lessons Learnt.

- Language such as 'relationship difficulties' should be used with caution in a DHR as it could be perceived as victim-blaming.

- The QA Panel felt that the report could have considered some aspects in more detail:
    - There could be more consideration of the economic abuse involved.
    - The report could also indicate whether Adult B was questioned about how frequently he engaged in clay pigeon shooting, given this was the grounds on which he was provided with a shotgun license.
    - The report could also delve more deeply into how Adult B's alcohol consumption might have impacted his behaviour and relationship dynamics.
    - The report could further consider that there appears to have been a significant reliance on self-reports from Adult B, e.g. in relation to his shotgun license renewals and interactions with professionals. This over-reliance might have led to an underestimation of the risks he posed.
    - The report could also consider the missed opportunities for intervention, for instance the downgrading of the initial assessment by

the Multi-Agency Safeguarding Hub to green, and the return of the shotguns to Adult B.
    - The report should also indicate whether it is known why there was no DASH risk assessment completed for Emma on the occasion when she was arrested.
    - There could also be some reflection on the appropriateness of relationship counselling when Adult B was behaving abusively to Emma, including in the counselling sessions themselves.
    - Finally, the DHR could also consider instances of inadequate follow-ups. Particularly in the case of Lettie's developmental review and insufficient engagement following Emma's report of domestic abuse to East Surrey Domestic Abuse Service. After the 2016 incident, there was limited communication with Emma about her safety and wellbeing, despite her history of reporting domestic abuse. The report could have placed greater emphasis on the potential long-term effects of living in an environment with domestic abuse on Lettie. The decision to downgrade the risk assessment without thoroughly evaluating Lettie's surroundings is troubling. Consistent and proactive engagement would likely have offered better support for both Emma and Lettie.

- There are references to the Coroner's Inquest which are incomplete and require updating, and the report requires a thorough proofread for typos and grammatical errors.

- There are some omissions in the report layout, notably there is no glossary of terms and no dissemination list. It is also good practice to provide a table detailing all of the agencies first contacted by the review.

- There is no titled action plan, and no titled section on the Chair's independence, and more information could be added regarding whether the Chair has worked in this area on DHRs before, and also on what date the CSP appointed the Chair.

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

Response to feedback from Home Office Quality Assurance Panel re: Domestic Homicide Review (DHR) report (Emma, Lettie & George)

	Feedback	Response
1	The QA Panel felt that the contribution in the tributes section from George's father would be better placed in another part of the report.	This paragraph has been moved to para 5.1.4
2	The report emphasises the importance of sharing the findings of this DHR with the local Surrey Safeguarding Children's Partnership, but there is no further information on this action and whether it happened. This action should also be included in the dissemination section of the report which has not been completed.	A full dissemination list has now been added to the report.
3	There is no information on the time-period covered by the review, and there should be more information regarding the decision-making process behind the decision to hold the DHR and which agencies/partners were involved.	An additional sentence has been added at para 2.1 (e), stating, *The period for review by agencies spanned from any contact recorded in agency records, especially from the initial application for a gun license by George in 2012.*
4	There is no equality and diversity section. It is important to consider the specific protected characteristics of the victims and perpetrator and how these relate to domestic abuse. Where equalities were mentioned, the QA Panel felt it flipped between the victims and George, when the review should focus on the victims.	There is a whole section on this, at section 5.6. This is clearly stated in the contents page table so we consider this point of feedback to be inaccurate.
5	Paragraph H on page 5 mentions delays due to the Home Office Quality Assurance Panel were a significant issue. This is inaccurate as the DHR had not been submitted to the Home Office at that time.	This sentence was included in the safe knowledge that there would be significant delays due to the Home Office Quality Assurance Panel – by the time this review is published, it will be accurate. The draft report was submitted to the Home Office in March 2024, and we were advised that it would not be reviewed until August 2024 – representing a five-month delay. Paragraph 5 has been amended to accurately reflect this timeframe.

6	The names used in the report should be set out earlier than in section 3.4	The following statement has been added to the front sheet; *Family members have expressly requested real names be used in this report.*
7	Consideration of the eight-stage homicide timeline should be in the Analysis section rather than Lessons Learnt.	The independent Chair and report author for this review has used his experience and discretion to decide where the reference to the eight-stage timeline should be located. He considers that it might get lost in the analysis section. For those that read the report by going straight to the Lessons Learnt section, it might promote learning. The timeline is a useful resource and promoting its application is a point for learning. We believe the flow of the report, on this issue is helpful – no changes have been made.
8	Language such as 'relationship difficulties' should be used with caution in a DHR as it could be perceived as victim-blaming.	Minor adjustments have been made at the following points where this term has been used: 4.3.1, 5.1.2, 5.1.9, 5.1.11, 5.2.8, 5.3.8, 5.4.1, 7.2
9	The QA Panel felt that the report could have considered some aspects in more detail: a) There could be more consideration of the economic abuse involved. b) The report could also indicate whether George was questioned about how frequently he engaged in clay pigeon shooting, given this was the grounds on which he was provided with a shotgun license. c) The report could also delve more deeply into how George's alcohol consumption might have impacted his behaviour and relationship dynamics. d) The report could further consider that there appears to have been a significant reliance on self-reports from George, e.g. in relation to his shotgun license renewals and interactions with professionals. This over-reliance might have led to an underestimation of the risks he posed. e) The report could also consider the missed opportunities for intervention, for instance the downgrading of the initial assessment by the Multi-Agency Safeguarding Hub to green, and the return of the shotguns to George.	We thank the Home Office Quality Assurance Panel for these feedback points about what the review ***could*** have considered further. We are satisfied that the current content of the report on these issues is reasonable and proportionate, and that the Independent Chair has identified the key areas of learning. The Chair will reflect on these points for future learning, but we do not consider any changes are needed. Our response to the individual points raised is set out below: a) We have limited information or evidence to write about economic abuse. The Independent Chair will keep this in mind for future reviews and has taken this as a learning point. b) We are unsure what this would add to the report or the learning. High or low usage is irrelevant to the issuing of a gun license. It would add unnecessary wordage to an already lengthy report, and provide no added value. c) The report does reference and explore alcohol use many times. It also concludes with a recommendation to the Home Office to strengthen the gun licensing process. We cannot therefore, agree with this point. d) The report does conclude with a recommendation to the Home Office to strengthen the gun licensing guidance in respect of seeking the views of other adult members of the applicant's household about the licence application, the holding of weapons in the home, any relevant medical conditions i.e. alcohol consumption, or additional issues including the presence of domestic abuse,

	f) The report should also indicate whether it is known why there was no DASH risk assessment completed for Emma on the occasion when she was arrested. g) There could also be some reflection on the appropriateness of relationship counselling when George was behaving abusively to Emma, including in the counselling sessions themselves. h) Finally, the DHR could also consider instances of inadequate follow ups. Particularly in the case of Lettie's developmental review and insufficient engagement following Emma's report of domestic abuse to East Surrey Domestic Abuse Service. After the 2016 incident, there was limited communication with Emma about her safety and wellbeing, despite her history of reporting domestic abuse. The report could have placed greater emphasis on the potential long-term effects of living in an environment with domestic abuse on Lettie. The decision to downgrade the risk assessment without thoroughly evaluating Lettie's surroundings is troubling. Consistent and proactive engagement would likely have offered better support for both Emma and Lettie.	coercion and control. The views of other adult members of the applicant's household should be sought separately, and not in the presence of the applicant, to avoid any fears or concerns about disclosure. We cannot therefore, agree with this point. e) The decision taken to downgrade the initial assessment by the MASH was proportionate and evidence based (as stated in para 5.1.4.). The report then goes on to consider learning (para 5.1.5) for the MASH about consideration of Emma's professional role. This is accepted as a learning point. We do not consider any further narrative will add value. f) As stated, a DASH assessment was completed for George – the perceived victim at the time, and not Emma. The Police did follow due process but as detailed, have reflected on this incident (with the benefit of hindsight) from the perspective of the victim being subject to coercion and control. g) We do not consider this would add any further value to the analysis, learning, or recommendations. h) In terms of a perceived inadequate follow up by the Health Visiting Service re developmental reviews, we believe the report has adequately covered this point. In terms of the 'insufficient engagement' with the East Surrey Domestic Abuse Service, the level of engagement was led by Emma. The report does provide a learning point about the effects on children of living with domestic abuse. As the report states, our appreciation of the effects on children of living with domestic abuse has increased over the years, and especially since the 2016 incident. We do not consider any changes to this area are needed.
10	There are references to the Coroner's Inquest which are incomplete and require updating, and the report requires a thorough proofread for typos and grammatical errors.	This is an inaccurate point of feedback. Para 1.10, 2.1 (c), 2.1 (h), Section 5 (1), Para 5.3.20, and para 5.7.3 all reference the Coroner.
11	There are some omissions in the report layout, notably there is no glossary of terms and no dissemination list. It is also good practice to provide a table detailing all of the agencies first contacted by the review.	The Independent Chair and author of this report, did not consider a glossary was needed for this report. Section 2, Table 1 does already provide a list of all agencies first contacted by the review.

12	There is no titled action plan, and no titled section on the Chair's independence, and more information could be added regarding whether the Chair has worked in this area on DHRs before, and also on what date the CSP appointed the Chair.	The final two sentences of Para 2.1 (b) clearly refer to the Chair's independence. His date of appointment, in April 2023, has been added to para 2.1 (b).

Epsom and Ewell
Community Safety Partnership

Epsom & Ewell
Community Safety Partnership

Domestic Homicide Review
into the deaths of
Emma, Lettie & George

(All of whom died in February 2023)

Family members have expressly requested real names be used in this report.

Independent Chair & report author: Kevin Ball

Date: October 2024

The following extracts of a tribute to Emma and Lettie have been kindly provided by family members:

Aside from her professional life, Emma was everything one could possibly hope for in a daughter, a sister, a wife, a mother, and a friend. Lettie was her pride and joy, a vibrant little girl who seemed to have just absorbed all her mother's goodness, vitality, and love. She was a beautiful, charismatic human being, adored by all who knew her.

Emma … grew up with chickens, ducks, geese, Labrador dogs and ponies Dolly and Zerco. Where they lived there was a quiet area of the farmyard on the edge of a wood, away from all the tractors, and here Emma and her sister created their own adventure playground …

Emma excelled in languages and playing the piano … completed A levels and gained a place at University to study English Literature and French and took an active part in student life … music always played a big part in Emma's life and she became a competent, engaging, and entertaining piano/vocalist. … From an early age it was obvious to her family that Emma was destined to become a teacher … Emma was very ambitious and rightly so …

… A former Head that Emma worked with, said that Emma was a dynamic but thoughtful leader; '… She asked for advice and weighed up her options when caution was required, but she could also be bold and innovative. Emma always listened and was willing to take on board the opinions of others, this empowered those under her and instilled in them a professional self-belief. There are many colleagues working in our schools today who are grateful to Emma for her time, her thoughtfulness, and her insight'.

One former colleague said 'She led with purpose, ambition and energy, a truly strategic thinker who worked tirelessly to deliver in every aspect of her leadership role with humility, energy and drive'. Another former colleague reflected 'She brought with her such joy and positivity, aligned to a titanic ambition, that those around her felt bigger, better, more able. But Emma was also disarmingly humble and wasn't afraid to ask the simplest of questions, to listen, to learn and to accept guidance from wherever it came'. One of her pupils wrote, 'She gave me a voice when I didn't feel that I had one and because she made me feel genuinely cared for, she gave me self-worth. She gave me understanding, she gave me encouragement, she gave me kindness but most of all, she gave me hope'.

What can you say about a little girl who died? Except that she loved her Mummy and Daddy, her Aunties, her Uncles, her cousins, her dog Bella, and she loved us, her Granny and Grampa.

She loved Christmas mornings, rushing round dragging everyone out of bed at some unearthly hour shouting "He's Been, He's Been!" On Easter Sunday she loved searching the house and garden, unearthing and deciphering clues, all leading her to the hiding place of the next cream egg. She also loved Horrid Henry, Paw Patrol and anything that came out of some place called Arendelle; she loved karaoke, she loved the bedtime stories, she loved going to school and taking part in all her many sporting activities. … But above all she loved life. Our memories of our time spent with her are ones of fun, laughter, and adventure. … her never-ending gym displays and cartwheels, taking her swimming, playing netball, and going on long walks with Bella. She was intelligent and articulate way beyond her years and her giggly laugh and engaging smile brought charm and delight to everyone who met her. On long car journeys she was unbeatable at both "I Spy" and "Animal, Vegetable or Mineral"

Lettie would have had a dazzling future and the loss to the world of that future saddens us greatly. But what saddens us more is her loss of that sparkling, larger-than-life enjoyment of the here and now … in everything that she did.

1. Introduction to the review

1.1. This Domestic Homicide Review (DHR) examines the contact and involvement of professionals and organisations with Emma, Lettie, and George, all of whom died in February 2023. The shocking and unexpected nature of their deaths has left all that knew them, but especially family members deeply saddened. The Epsom & Ewell Community Safety Partnership, and the Independent Chair of this DHR wish to extend their condolences to all family members. Representatives of the family, from both maternal and paternal sides, have either been involved in helping shape this review, or been offered the opportunity to contribute; the Independent Chair is extremely grateful for their insights and contributions at such a difficult time. It is hoped that the review will influence learning and change, thereby reducing the likelihood of future similar tragic incidents occurring.

1.2. A former work colleague has described Emma;

'… Emma was universally liked. She successfully navigated being a head of a school and being human. She had humanity and she really cared for the pupils, staff, and parents. She turned School 1 around and this included how the wider public perceived the school … Emma was well-liked by parents and pupils, and she made it her business to know everyone in the school and would always greet you with a smile …'.

1.3. A long-time friend reflected on her friendship with Emma as being;

'… a very caring and empathetic person. … She was loyal and moral. I saw that in how she led our school and in how she supported me and my children. She would have found it difficult to be critical of George and to ask for help. It has been a great sadness to me that I did not understand the danger of the situation she and Lettie were in …'

1.4. Those that knew Lettie offered their reflections;

'… a happy and vibrant member of the class, [telling] stories of home life which demonstrated happy times being experienced as a family. Grandma was a particular highlight at pick up [time] …'.

1.5. The circumstances of the family under review are that the Police were called to the family home to find Emma (aged 45 years), Lettie (aged 7 years) and George (39 years) all deceased; all three members of the family had died as a result of gunshot. Police investigations confirmed that George was a licensed shotgun holder, and that he had killed his partner, Emma, and their seven-year-old child, Lettie. No specific motive about why George acted in this way has been uncovered.

1.6. The Domestic Violence, Crime & Victims Act 2004 sets out the circumstances when a Domestic Homicide Review should be considered referring to the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse, or neglect by a) a person to whom he/she was related or with whom he/she had been in an intimate personal relationship, or b) a member of the same household as himself/herself. Using this criterion, the Epsom & Ewell Community Safety Partnership determined in March 2023, that a review should be completed. The terms 'familicide' – a term used to describe the murder-suicide with the nuclear family where the spouse and children are killed[1] will be used in this report.

1.7. Based on statutory guidance[2], the purpose of any Domestic Homicide Review 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;

[1] Scahmann, M., & Harris Johnson, C.M., The relevance of long-term antecedents in assessing the risk of familicide-suicide following separation, Child Abuse Review, vol.23: pp 130 – 141, 2014, Wiley.

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016, Home Office.

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 coordinated 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.

1.8. Given the death of a child, the Surrey Safeguarding Children Partnership were notified and a Rapid Review was conducted, in accordance with statutory guidance[3]. The Rapid Review Panel decided not to conduct a separate local Child Safeguarding Practice Review (LCSPR) but instead to ensure that their findings were shared with the DHR panel. Whilst the Child Safeguarding Practice Review Panel[4] were informed and agreed with the decision of the Surrey Safeguarding Children's Partnership not to conduct an LCSPR, they did highlight that under the circumstances, a review could have been undertaken. Given this, it will be important for the findings and learning from this review to be shared with the Surrey Safeguarding Children's Partnership but also the Child Safeguarding Practice Review Panel.

1.9. In parallel to the DHR, a Child Death Review process has been ongoing and will be examining similar information as submitted to the DHR.

1.10. Domestic Homicide Reviews are not inquiries into how a person died or who was responsible for the death; those are matters for HM Coroners and criminal courts respectively to determine as appropriate. Surrey Police have conducted a thorough investigation into the circumstances of the deaths. In July 2024 HM Coroner (Surrey) determined that Emma and Lettie were unlawfully killed, and that George died by suicide.

2. Methodology for conducting the review

2.1. Following the decision in March 2023 to commence a DHR the following steps were taken;

a) Requests for preliminary information about any contact or involvement with the family were made to the following agencies, as set out in Table 1 below;

[3] Working Together to Safeguard Children, 2018, HM Government.

[4] Child Safeguarding Practice Review Panel is an independent panel formed under the Children & Social Work Act 2017 to consider serious child safeguarding cases.

Table 1: Agency information requests	
Surrey County Council Adult Social Care	North Surrey Domestic Abuse Services (Outreach)
Surrey County Council Children's Services	Probation Service
Surrey Police	Surrey & Borders Partnership NHS Foundation Trust
Your Sanctuary (Outreach) – Domestic Abuse Services	East Surrey Domestic Abuse Services (Outreach)
Surrey Heartlands Integrated Care Board – Health	South West Surrey Domestic Abuse Services (Outreach)

b) The Chair of the Epsom & Ewell Community Safety Partnership appointed Kevin Ball as the Independent Chair and report author for this Domestic Homicide Review in April 2023. He is an experienced independent Chair and report author, notably of cases involving the harm or death of children, but also Domestic Homicide Reviews. This is the second DHR he has undertaken which has examined familicide as a result of death by a licensed shotgun holder[5]. He has a background in social work, and over 32 years of experience working across children's services ranging from statutory social work and management (operational & strategic) to inspection, Government Adviser, NSPCC Consultant, and independent consultant; having worked for a local authority, regulatory body, central Government, and the NSPCC. Over his career, he has acquired a body of knowledge about domestic abuse through direct case work, case reviews and audit, and research and training – all of which supports his work as a Chair and reviewer of Domestic Homicide Reviews. During his career, he has worked in a multi-agency and partnership context and has a thorough understanding about the expectations, challenges, and strengths of working across complex multi-agency systems in the field of public protection. In the last 10 years he has specifically focused on supporting statutory partnerships identify learning from critical or serious incidents and consider improvement action. He has contributed to the production of Quality Markers for Serious Case Reviews, developed by the Social Care Institute for Excellence & the NSPCC – which are directly transferable and applicable to the conduct of Domestic Homicide Reviews. He has completed the Home Office on-line training for Domestic Homicide Reviews and the Chair training course provided by Advocacy after Fatal Domestic Abuse (AAFDA). He is a member of the national Child Safeguarding Practice Review Panel's pool of reviewers available for national reviews. In April 2024 he was appointed by the Home Secretary as the third Panel member for the new pilot Home Office Offensive Weapons Homicide Review Oversight Board established under the Police, Crime, Sentencing and Courts Act 2022. He has no association with any agencies involved and is not a member of the Surrey or Epsom & Ewell Community Safety Partnership, and has never worked for any agency in the local area, or been a part of either Partnership. As such, there was no conflict of interest.

c) In April 2023 initial discussions were held between the Police Senior Investigating Officer and the Independent Chair to assist the Independent Chair gain a better understanding about the Police investigation. Given the circumstances, ongoing contact was maintained between the Independent Chair and the Senior Investigating Officer throughout the process of the DHR as necessary, and up until the conclusion of HM Coroner's Inquest in July 2024; this was to assist with the mutual identification of learning and possible improvement activity.

d) In May 2023 an initial Review Panel meeting was convened to provide oversight and scrutiny to the process, agree the Terms of Reference, offer relevant expertise and ensure the smooth and timely conclusion of the review.

[5] Domestic Homicide Review into the deaths of Adult A, Child 1 & Child 2, and George (All of whom died in March 2020), Executive summary, Kevin Ball, Safer West Sussex Partnership.

No members of the Review Panel had any direct management responsibility for any professional that might have had contact with any member of the family. Membership of the Review Panel is set out below in Table 2.

Table 2: Membership of the Review Panel		
Name	**Role**	**Agency**
Kevin Ball	Independent Chair & author	Independent Chair & report author
Maggie Pugh	Partnership Development and Engagement Officer	Surrey Safeguarding Children Partnership
Jo Millward	Head of Domestic Abuse, Family Resilience and Adolescence Commissioning	Surrey County Council
Helen Milton	Designated Nurse for Safeguarding Adults	Integrated Care Board (ICB)
Andy Pope	Statutory Reviews Lead	Surrey Police
Nicola Eschbaecher	Designated Nurse for Child Death Reviews	Surrey Heartlands NHS Integrated Care Board (ICB)
Michelle Blunsom	Chief Executive Officer	East Surrey Domestic Abuse Service (ESDAS)
Patricia Denney	Director of Quality Assurance and Performance	Surrey Children's Services
Francesca Hyde	Community Safety Officer (Minutes)	Epsom & Ewell Borough Council on behalf of Epsom & Ewell CSP
Oliver Nelson	Public Protection Manager (Attending on behalf of CSP Chair)	Epsom & Ewell Borough Council on behalf of Epsom & Ewell CSP
Georgia Tame	DHR Coordinator	Surrey County Council
Kate Charles	Deputy Service Manager	School Relationships and Support for Surrey
Jane Stapleton	Adult Safeguarding Lead	NHS - First Community Health and Care

e) This initial Review Panel meeting also made the formal request to all relevant agencies to complete chronologies and an Individual Management Report (IMR). The period for review by agencies spanned from any contact recorded in agency records, especially from the initial application for a gun license by George in 2012. From the initial trawl of information from those agencies set out in Table 1, the agencies detailed in Table 3 below were asked to complete and submit an Individual Management Report. All report authors were independent, having had no direct management responsibility with any practitioner that may have had contact with members of the family.

Table 3: Individual Management Reports submitted	
Surrey Police	East Surrey Domestic Abuse Service (ESDAS)
Surrey Children's Services	Surrey and Sussex Healthcare NHS Trust
First Community Health & Care	School 1
GPs – via Surrey Heartlands NHS Integrated Care Board	School 2
Private Hospital	School 3
Additional information sought, and provided by one former employer of Emma's and one former employer of George.	

f) Further meetings were scheduled as necessary, with a second Review Panel meeting taking place in June and December 2023 and February 2024 to provide scrutiny and quality assurance of Individual Management Reports that had been submitted, as well as examine learning. All Review Panel meetings were held virtually by video. The time gap in between Review Panels was due to waiting for information to be submitted.

g) Following the initial Review Panel meeting in May 2023 the Independent Chair contacted members of the maternal and paternal family to discuss the review process and seek their views for the review.

h) The final report was presented to the Epsom & Ewell Community Safety Partnership in March 2024. As such, the review process took 12 months to complete, six months longer than the indicative timescales provided by the Home Office. The review took longer to finalise due to awaiting the conclusion of the Police investigations. The review was submitted, in draft and not for public viewing, to the Coroner's Office in March 2024 to assist with preparations for the Inquest, prior to it being quality assured by the Home Office Quality Assurance Panel. The draft report was also submitted to the Home Office Quality Assurance Panel in March 2024, and then reviewed by them in August 2024, with the Partnership hearing back in at the end of September 2024 – this resulted in delays to the report being finalised and published.

i) The final report and action plan have been shared with Community Safety Partnership, Surrey Safeguarding Children Partnership, Surrey DHR Oversight Group, Surrey Domestic Abuse Management Board, the Leader of the Council, the Office of Surrey Police & Crime Commissioner (OPCC), and all the agencies involved on the DHR Panel.

j) The detailed findings of all information provided to the review remained confidential. Information was available only to participating professionals and line managers. A confidentiality agreement was signed by DHR Panel members at the commencement of the DHR and reconfirmed at the start of each Panel meeting.

2.2. The following lines of enquiry were agreed by the Community Safety Partnership and Review Panel;

1. Explore any information that was known by agencies, services, professional, family, friends, or work colleagues, that helps us understand the quality of the adult relationship between Emma and George, but also them as individuals and independent professional people. To consider any aspects of controlling or coercive behaviour that may have been present in the relationship.

2. Examine information that helps us understand the adults individual, and combined, parenting capacity.

3. Explore the quality and effectiveness of the shotgun licensing process e.g. initial application & assessment, renewals, weapon security, risk management, other relevant factors.

4. Examine whether the work undertaken by services in your contact was consistent with your organisation's a) professional standards, b) domestic abuse & violence policy, procedures & protocols, and c) safeguarding adults & safeguarding children's policy, procedures and protocols, d) staff welfare policy and procedures. This is applicable to universal services such as schools and health services, plus, any specialist or independent services that were used by either parent i.e. counselling services and mental health services.

5. To consider any barriers experienced by the victim or her family/ friends/ in reporting any abuse (including any aspects of coercive and controlling behaviour) including whether the victim knew how to report domestic abuse should she have wanted to. E.g. maternal and paternal sides of the family, close friends, work colleagues

6. Any issues that may be relevant arising from protected characteristics as set out in the Equality Act 2010 i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

7. Whether the impact of any organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively i.e., changes or the introduction of domestic abuse policies, training, Covid-19 etc.

3. Family contributions to the review

3.1. Seeking the contributions of family members has been an important consideration for this review.

3.2. With the involvement of Victim Support[6] and the Police Family Liaison Officers members of both Emma and George's family agreed to contribute to the review. Information about AAFDA[7] was also provided but their support was not taken. Both sides of the extended family have been clear from the outset that they hope the DHR can capture learning that can be used to prevent future similar tragedies occurring. The draft lines of enquiry were shared with the family representatives to seek their views. Contact was maintained by the Independent Chair with both sides of family throughout the review process and to provide updates when helpful to do so, as well as seek information. Members of both sides of the family have seen the draft report, had opportunity to comment on it, but also shape recommendations. Their insights have been hugely helpful.

3.3. Information from the Police investigation, and witness statements, was used to assist the Independent Chair assess whether friends and other non-professional contacts might be able to assist the review. Follow-up by the Independent Chair with some former work colleagues and friends of both Emma and George was conducted. Additional information has been sought, and provided from, former employers of both Emma and George that went beyond information gathered by the Police; although this was not via a formal request of an IMR as this was not considered proportionate. A total of eight additional sources of information were obtained from friends, former work colleagues or employers of both Emma and George.

3.4. Members of the extended family, from both sides, have been consulted about names to be used in this report. All have confirmed that they wish for real names to be used.

[6] Victim Support is an independent charity that provides support to anyone affected by a crime, Victim Support

[7] AAFDA – Advocacy after fatal domestic abuse is a charity and centre of excellence for reviews after fatal domestic abuse and for expert and specialist advocacy and peer support.

3.5. Emma and Lettie's family have commented on some of the findings of this review and how this might translate into learning and improvements '*… We agree that healthcare and other professionals should use all opportunities to be curious about potential abuse situations and when they do so to specifically refer to coercive control and emotional abuse using specifics including the types of things it covers with examples. However, we also believe there should be a clearer and wider public understanding of this type of abuse and, importantly, what it looks like. We think that many sufferers will struggle to appreciate what is happening to them even where they are intelligent people actively involved in these matters. … [also] … the fact that the instances of abuse were scattered among good times … can make things very difficult to spot - for anyone, not least the abused. Part of the nature of this type of abuse is its secrecy on the part of the abuser (and sometimes the abused) but it is also so often consistent with an abused individual being confused as to what is really happening: is it her fault … Is it really that bad? And also, 'we have all these other lovely times so on balance, things are generally fine'. All these elements hide coercive control and make it all the more insidious and cruel. They also make it more invisible …We also have a general thought about what is communicated when abuse is identified using these channels, in particular, are practitioners trained to discuss with victims what safe exit looks like and to help them plan it, or to put them in touch with people who can support that. Again, in our case, exit was the issue and it was clear Emma was struggling to manage the practical implications of physically leaving (safely with Lettie) or physically getting George to leave …'*.

4. Summary of relevant family history & key events

Table 4: Members of the household

Identifier	**Status**
Emma – partner to George and mother to Lettie	Victim
George – partner to Emma and father to Lettie	Perpetrator
Lettie – child of both Emma and George	Victim

4.1. Both Emma and George, independently, had achieved successful professional careers. Emma had a successful career working in the teaching and education sector. George had a successful career working in the business sector.

4.2. Information set out below, in chronological order provides a factual summary of relevant history gained from agency Individual Management Reports. Chronological information and perspectives from former colleagues of Emma and George have been captured and although based on hindsight and open to outcome bias[8], are valid accounts and justify inclusion within the timeline.

4.3. Emma and George met and formed a relationship around 2006.

4.4. In 2009 George described suffering from work related stress and saw his GP; he was not prescribed any medication.

4.5. In 2010 Emma and George were married.

4.6. Following his application earlier in 2012, George was granted a shotgun licence in December 2012 for the purpose of clay pigeon shooting; this certificate was issued for a period of five years as per statutory guidance in place at the time.

4.7. Towards the end of 2013 Emma and George separated for a period of months, with Emma stating to a friend with whom she stayed with that she had experienced domestic abuse whilst living with George. Family members

[8] Outcome bias – a bias formed based on trying to evaluate information whilst already knowing the outcome.

have confirmed that Emma refused to return until George's attitude changed and until he became more respectful towards her. They would meet periodically in public places, with Emma often leaving early because of George's foul language, but eventually George appeared to acknowledge that he needed to make changes to his treatment of Emma.

4.8. In early January 2014 George disclosed having marital problems to his GP and suffering anxiety as a result of a trial separation - he was keen to address the issues that contributed to that. His GP referred George to a Consultant Psychiatrist, who met with him twice in 2014 and found no psychosis or psychiatric problems, just relationship problems. The Consultant Psychiatrist stated that George did not want details shared with his GP as he was concerned about any implications in relation to his shotgun licence. During the meetings with the Psychiatrist, George discussed his alcohol consumption and the management of that; he also disclosed the fact that Emma was seeing a marriage counsellor. The outcome of these two meetings with the Psychiatrist was that a referral was made for George to have some cognitive therapy from another professional. The Psychiatrist described how George was having difficulty in his personal life but had given him some general lifestyle advice and did not believe medication was required. A Therapist met with George four times and it was noted that George wished to address the apparent frustration and intolerance that had been raised in the marriage counselling sessions. In 2014 the Therapist wrote to George's Psychiatrist stating that George and Emma were trying to resolve their difficulties however, fundamental personality differences represented an area of concern for George; it was also noted that George had taken steps to reduce his alcohol intake and gain control of his emotions.

4.9. Between January and July 2014 Emma met with a Counsellor from a local Relate service 11 times; it is not known if George was aware of these sessions taking place. Due to data retention policies the content of these sessions has been deleted with only basic personal details and attendance dates being retained. Emma and George also then had 12 sessions with an independent Psychologist between January and May 2014 – the initial assessment described them arguing, not getting on well and not listening to one another. A final communication between Emma and the Psychologist in May stated that the sessions were not working, and Emma and George were separating. In addition to trying to find ways of not arguing, it was reported during the sessions that George had spat, swore, and used abusive terms towards Emma.

4.10. Also, in January 2014 Emma contacted the East Surrey Domestic Abuse Service (ESDAS), having been provided their contact details by her GP. Concerns raised included having recently moved out of living with George, and indications about financial and emotional abuse. This referral resulted in Emma meeting with a worker from ESDAS, Emma disclosing being called names by George, being pushed by him, and efforts by him to try to isolate her from friends. She shared that she realised that she was spending a lot of time in the spare room, crying, explaining how she had tried to tell George how she felt, but he just told her that she was being 'too sensitive'; Emma had started to wonder if George was right, and if this was the case. Emma also shared that she had started to look for private counselling. The ESDAS worker offered ongoing support and also provided her with the Surrey 24-hour helpline number, as she worked long hours which made it more difficult for her to call in 'office hours'.

4.11. In 2015 Lettie was born. Emma had attended all routine antenatal care appointments and routine questions about domestic abuse were asked – no information of concern was provided by Emma. Routine Health Visiting appointments were attended and again, no issues of concern were noted. George was not recorded as being present during any of these appointments however this is not necessarily unusual for father's to be absent from these appointments. During the first new birth visit, the routine enquiry questions relating to domestic abuse were not asked due to Emma's mother also being present, and good practice guidance advising that such questions should not be asked when others are present. It was noted that Emma was not living close to extended family networks but no concerns were raised about levels of support. The attachment between Emma and Lettie was noted as warm and loving. A Universal[9] level of service was offered, as no unmet needs were identified.

[9] A universal service from health visitors and their teams, providing the full Healthy Child Programme to ensure a healthy start for children and family, support for parents and access to a range of community services/resources.

4.12. In March 2016, First Community Health & Care Health Visiting Service sent a letter inviting Lettie's parents to contact and make an appointment for the 9–12-month Developmental Review; there is no record of a response, or a review being carried out. It was not standard practice to follow up on universal families that do not attend.

4.13. From April 2016 Emma received intermittent prescriptions from the GP for anxiety and stress, reported as being due to working full time and having a young child. She received intermittent treatment for this over the following years, but never requested or appeared to need other treatment. Emma then had no contact at all with her GP Practice between December 2016 and March 2019.

4.14. In May 2016 Emma is recorded as assaulting George. The Police attended the incident having been called by George. Both parties were separated by the Police, accounts of the incident were provided, with Emma admitting that she has slapped George following an argument where he had poured water into her new handbag; Emma was described as showing genuine remorse and told Officers there had been recent problems in the marriage and they had been attending regular counselling. George stated that they had been arguing over Emma's work, but also mentioned marital problems and counselling. He also disclosed that in the past Emma had *'swatted him whilst the two were in bed if they have argued in the past …',* but did not want to discuss that any further with the Officers. George did not want the Police to take any further action and made it very clear that had he known what the Police response would involve he would not have called them.

4.15. The attending Officers completed a Domestic Abuse, Stalking, Harassment & Honour Based Violence Assessment tool (DASH)[10], with George. The majority of questions he answered with *'no.'* George was asked '*are you currently pregnant or have you recently had a baby (in the past 18 months)?'* to which George appropriately answered *'yes'*, as at the time Lettie was 12 months old. Another question asked of George was, are there *'other relevant information (from victim or officer) which may alter risk levels (consider for example victims' vulnerability, disability, mental health, alcohol/substance misuse, and/or the abuser's occupation/interests – does this give unique access to weapons i.e. ex-military, police or pest control)'*. George responded '*yes*' to this question and the fact he possessed two shotguns - whilst this is written in the free text box of the form, it is not clear whether this was disclosed by George or was discovered via a check of Police records undertaken by the officer. The risk level for this incident was rated as 'standard', which is defined as *'… current evidence does not indicate the likelihood of causing serious harm …'*[11].George clearly expressed that he did not want the form shared with other agencies, and he declined any referral to independent outreach services. The officers discussed the DVPN[12] process with George, but he had no interest in any civil injunctions and repeatedly told Officers he had made a mistake in calling the Police.

4.16. Although Lettie was only 12 months old, she was awake and being comforted by her mother. The Officers completed a Child at Risk Form (now known as a Single Combined Risk Assessment - SCARF), a requirement when a child comes to the attention of the police. On completing this form, the Officers described both Emma and George as respectable professional individuals with no concerns about their ability as individuals to care for Lettie, who appeared healthy, well dressed, and cared for. The Officer did however express concern about the potential emotional impact on Lettie following this incident and recorded this on the multi-agency referral form, and giving it a grading of 'Amber'[13].

[10] The DASH tool (Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment) is part of the Multi Agency Risk Assessment Co-ordinator (MARAC) referral. It's a risk assessment form to help you work out the risk level for the victim.

[11] College of Policing, Risk-led policing of domestic abuse and the DASH risk model, 2016.

[12] DVPN - Domestic Violence Protection Orders. A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. It is a civil order that can provide protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions.

[13] MASH process guidance, Surrey County Council, March 2017.

4.17. In this case a power of arrest did exist, and the Officers chose to arrest Emma in accordance with the policy. Upon release Emma was driven home by the Officers and it was recorded that she would be given advice about outreach domestic abuse services that provides support services for victims of domestic abuse. It is offered to all victims regardless of whether the risk is Standard, Medium, or High.

4.18. The Child at Risk Form completed by the attending Officers was sent into the Multi-Agency Safeguarding Hubs [14] (MASH) which comprised a number of partnership agencies co-located to safeguard children and vulnerable adults and is made up of professionals from Police, Health, Children's Social Care, Education, Adult Social Care and Mental Health. The Police within the MASH independently assessed the form and, in this case, downgraded the initial assessment from 'Amber' to 'Green'[15]. The rationale for downgrading was based on this being the first incident of domestic abuse known to services, the fact Emma had not been charged with any offences and that there were no obvious and immediate concerns for the welfare of Lettie. This form was shared with Surrey Children's services.

4.19. On receipt of the Child at Risk notification, Surrey Children's Services Social Worker completed a check of the Surrey Children's database to confirm if the family were previously known to Surrey Children's Services – no information was found indicating no previous involvement. The Social Worker and Team Manager agreed that threshold was not met for further intervention from Surrey Children's Services and a single letter was sent to Emma and George highlighting the impact of parental acrimony on children. There is no evidence of either Emma or George responding to the letter, and as such, there was no further contact from Surrey Children's Services with the family. At the time of this incident, Emma worked at School 4.

4.20. Following the assault allegation where George was recorded as the victim Police seized both his shotguns and he surrendered his certificate at the time. This was in accordance with the Domestic Abuse policy. A home visit was made to both George and Emma in June 2016 by a Firearms Enquiry Officer where both adults were spoken to separately. Emma told the Officer she was surprised her husband called the Police over such a trivial matter and stated their relationship was now good and she had no safety concerns relating to the return of her husband's shotguns. George told the Officer the reason he called the Police was to impress upon his wife that she should not resort to violence to resolve matters and he only wanted to frighten her. He stated if he knew she would have been arrested he would not have called the Police. A report was submitted to the Superintendent responsible for the Firearms Licensing Unit in Surrey Police recommending the return of the shotguns based on the assessment of the circumstances, no previous domestic abuse history or antecedent history or other significant risk to public safety or the peace justifying a revocation. The shotguns were returned.

4.21. In September 2016 Emma started a new job as a Headteacher at School 1.

4.22. In December 2016 George applied to renew his shotgun certificate; this application which was granted for a further five-year period as per statutory guidance in place at the time.

4.23. In October 2017 First Community Health & Care, Health Visiting Service completed a 27 – 30-month developmental review for Lettie. No developmental concerns were noted. Based on policy guidance, as Lettie was now over two years of age, routine enquiry questions of the mother about issues such as domestic abuse, were not asked in the presence of a child over this age.

4.24. Emma visited her GP in March 2019, again with stress and anxiety related symptoms, detailing a high alcohol intake of 2-3 drinks per night and stress at work. Similar circumstances were described later in September 2020

[14] The Surrey Multi-Agency Safeguarding Hub (MASH) is the single point of contact for reporting concerns about the safety of a child, young person, or adult. It aims to improve the safeguarding response for children and adults at risk of abuse or neglect through better information sharing and high-quality and timely responses.

[15] MASH process guidance & Red/Amber/Green ratings explanatory guidance document (RAG Surrey, updated March 2016), Surrey County Council, March 2017.

and March 2021, and included a specific reference to her husband struggling at home due to the Covid-19 restrictions.

4.25. In November 2021 Emma applied for a new job that would not begin, if successful, until August 2022; as part of the application and recruitment process, Emma and George completed a self-declaration where both declared that they had no criminal records, sanctions, restrictions, or prohibitions. A Disclosure & Barring Service check[16] was completed on both Emma and George, and no information was recorded which impacted the appointment.

4.26. In February 2022, George's shotgun certificate was renewed for a further five years, again for the purpose of clay pigeon shooting and in accordance with statutory guidance in place at the time. Part of the renewal process included the requirement for the applicant to provide a medical assessment from their GP. Therefore, in December 2021 George's GP submitted an assessment form confirming there were no medical issues affecting George. The GP referred to two previous episodes in 2009 and 2014 described by the GP as '*discrete GP consultations at times of acute personal and work-related stress.*' The GP stated that George was not being treated for those matters and was not prescribed any psycho-active medication during each 'brief' episode. The requirement to seek a GP assessment resulted in a delay in the application process - the effect of which meant George did not have a valid certificate. To avoid breaking the law George lodged his shotguns with another registered certificate holder. Had he not of done this he would have committed a criminal offence of being in possession of a shotgun without a valid certificate which carries a maximum term of imprisonment of five years; lodging shotguns with another licensed holder is permitted practice under such circumstances.

4.27. During this renewal application a home visit was made by the Police, and the renewal form records that the two episodes of acute stress in 2009 and 2014 were discussed with George, during which he disclosed that the stress related matter in 2014 was following a separation from his wife for which they both received counselling. The matter in 2009 was work related. Based on the outcome of this visit, plus standard checks, the shotgun certificate was re-issued for a further period of five years.

4.28. Also in February 2022 Emma attended a local Minor Injuries Unit with a face injury, recorded as caused by a dog bite to her upper lip. Records state routine enquiry of domestic abuse was not made, and no safeguarding issues were identified. Emma reported she was accidentally bitten by her friend's miniature dog. Family members have subsequently confirmed this to be accurate and that there was no previous history of any physical abuse.

4.29. In March 2022 work colleagues of Emma noted tensions in her relationship with George during conversations in which she described of unrest which appeared to focus around the issue of the family home – notably about George not wanting to move house closer to Emma's forthcoming new job with School 2, but wanting to remain in the current family home where he had completed a lot of work over a number of years. Residing at the house on school grounds was a condition of employment for Emma. The outcome appears to have been that Emma gave an indication in late August that George would not be living in the new house but remain in the existing family home for the time being. It has been reported by one of George's close family members that he perceived a loss of autonomy and a sense of intrusion into his private life by living on-site.

4.30. In May 2022 Emma attended the Minor Injuries Unit alone with pain in her lower leg – recorded as being from playing netball an hour previously. Again, family members have subsequently confirmed this to be accurate. Medical assessment confirmed a muscle tear and she was provided with pain relief and advice. No routine enquiries were made at this time. One-week later Emma attended the Minor Injuries Unit alone stating she would be going away soon and wanted to know what she should/not be doing with her leg injury from last week. Following assessment, advice was given – again, there is no reference to routine enquiries being made which was in line with the standard operating procedure in place at the time.

4.31. Between May and September 2022 Emma received private medical treatment following a referral from her GP. The details of this episode are not relevant to the review however what is relevant is George's response to

[16] The Disclosure & Barring Service helps employers in England, Wales and Northern Ireland make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.

Emma's situation; members of Emma's family have confirmed that George showed no sympathy or care towards her symptoms and often cited these as being the cause of the difficulties in their relationship.

4.32. In August 2022 Emma moved job to take up the role of Headteacher at School 2 having successfully completed all the necessary recruitment checks.

4.33. In September 2022 Lettie started at a new school, School 3 – no concerns were identified and Lettie was observed to be happy, and steadily settling into a new school with a new group of friends.

4.34. In December 2022 another former colleague of Emma had a conversation with her, during which Emma stated that she wanted to leave George and divorce had been discussed between Emma and George.

4.35. In January 2023 Emma and George sold the former family home - George moved to live with Emma and Lettie.

4.36. In February 2023 Emma, Lettie and George were found dead at the family home. They all died by gunshot. Police investigations have confirmed that George was responsible for killing Emma and Lettie, before taking his own life.

5. Findings & analysis

1. The findings from the Police investigation into the deaths of Emma, George, and Lettie has concluded that George committed an intentional act in causing the deaths of Emma and Lettie, before then taking his own life. As noted, in July 2024 HM Coroner determined that Emma and Lettie were unlawfully killed, and George died by suicide. Before considering the agreed lines of enquiry, relevant and contextual information is set out below that attempts to place the familicide and mode of death in some context.

2. Familicide, the murder-suicide within a nuclear family where the spouse and children are killed, is a relatively rare occurrence. Research conducted by the Home Office[17] into Domestic Homicide Reviews notes that in 40 cases reviewed between January 2013 and March 2016 seven were familial homicides. Given its relative rarity, prevalence data is difficult to find which also makes prediction very difficult[18], if not impossible. Filicide however, the intentional killing of a child is sadly more common. NSPCC research[19] highlights that, as of September 2020, in the previous five years (2014/15 – 2018/19) there was an average of 84 child homicides a year in the UK. Child homicides are most commonly perpetrated by the child's parent or step-parent (31%). Despite a greater frequency, it is still nonetheless an occurrence that does not lend itself to predictability given the circumstances of each individual case. Trend data which combines filicide, adult homicide, suicide and/or familicide does not appear to exist.

3. The purpose of this DHR is not to speculate about the reasons why George acted in the way he did, taking the lives of his wife and daughter, before then it appears, also taking his own life. There is however a natural desire and tendency to ask 'why', particularly for close family members who will always be left with unanswered questions. For this review and family, sadly, we will never know the reasons. National and international research has been conducted exploring possible motives in other cases of familicide, citing a range of possible explanations. It is important to examine this as it allows us to consider whether there are similarities to what was known in this case (rather than speculating about the unknown), and then consider whether those similarities carry sufficient weight to apply to lessons which may be learnt because of this tragedy. However, and importantly, caution must be exercised when examining the findings of this research, and the information set out below, and then using it to draw conclusions linked to information uncovered as a result of the Police investigation and this review.

[17] Home Office, Domestic Homicide Reviews: key findings from analysis of domestic homicide reviews, December 2016.

[18] Berry, M. & Cliff, C., (2013), Parents who commit suicide after killing their children, Family Law.

[19] NSPCC Statistics Briefing: child deaths due to abuse or neglect, September 2020.

4. Research conducted by Debowska, A., et al (2015, p.120)[20] which examines the most recent studies of parental filicide notes '*… filicidal fathers were mostly motivated by marital problems (40%). Similar results were reported by Harris et al (2007) who found strong associations between paternal filicide and marital discord. Additionally, Kauppi et al (2010) asserted that 50% of men were motivated by jealousy. Anger, impulsivity, and revenge were also listed as most common motives in paternal child killing in a study by Putkonen et al (2011). This implies that filicidal fathers act out of strong negative emotions which are directed against the partner, rather than the child. Anger and impulsive reactions may arise from the lack of parenting skills and coping mechanisms, or the sense of personal inadequacy (Palermo, 2002). Male perpetrators were also noted for their antisocial behaviour in adolescence and adulthood (Kauppi et al, 2010) which, in conjunction with adverse life experiences, may lead to homicidal acts …'*.

5. Mailloux, S., (2014, p.923)[21] conducted research based on Canadian data noting limited research about the motives of perpetrators towards their child victims of familicide. This highlighted four possible motives; 1) Suicide: this being the perpetrator's need for suicide speculating '*… that the male perpetrator kills the spouse and children because he believes they are unable to go on without their head of household or patriarch … driven by a desire to protect the family from the shame of having a parent commit suicide …'*, 2) Immortality: '*… when the … perpetrator suffers from depression or other mental illness, he may kill his spouse and children in an attempt to immortalize the family; to keep everyone together as is … the perpetrator 'protects' the family from experiencing inescapable loss, believing that death is better than poverty …*'; 3) Control: '*… the perpetrator commits the final act of control by killing the entire family believing ' if I can't have them no one can … in such situations the perpetrator views the family as a singular unit and does not differentiate between individuals, which provides a possible explanation for the deaths of the children …'*, 4) Revenge: '*… revenge is often tied to sexual jealousy, where the perpetrator believes the spouse … has been unfaithful …'*. Mailloux noted that familicide is rarely an impulsive act. Websdale, N., (2010)[22] examines familicide and contends that '*… those who commit familicide experience overwhelmingly intense feelings of shame, fear, anxiety, and aggression that literally drive their acts of mass killing. …'*. Other research[23] notes that males represent the greater proportionate of familicide perpetrators, with guns being the most prevalent method used for familicide.

6. From a short review of a small number of research studies[24] there does appear to be some factors that are common across these studies in terms of contributory factors. These include, mental ill health, illicit substance use and misuse, alcohol use and misuse, stressful life events which may include financial stress as well as intimate partner conflict or dysfunction. Research conducted by the Home Office[25] into the seven familial homicides noted

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[20] Debowska, A., Boduszek, D., & Dhingra, K., Victim, perpetrator, and offense characteristics in filicide and filicide-suicide, 2015, Journal of aggression and violent behaviour, 21, pp 113 – 124. Elsevier.

[21] Mailloux, S., Fatal Families: Why children are killed in familicide occurrences, 2014, Journal of Family Violence, 29:921 – 926, Springer Science+ Business Media New York.

[22] Websdale, N., Familicidal hearts: the emotional styles of 211 killers, p. 46, 2010, Oxford University Press.

[23] a) Wilson, M., Daly, M., & Daniele, A., Familicide: The Killing of Spouse and Children, Aggressive Behaviour, Volume 21, pages 275-291 (1995), Wiley. b) Armeanu, A., Familicide: Psychological and Social Characteristics of the Aggressors. A Case Study, Source unknown c) Auchter, A., Men Who Murder Their Families: What the Research Tells Us, NIJ, Issue: 266.

[24] (a) McPhedran, S., Eriksson, L., Maerolle, P., De Leo, D., Johnson, H., & Wortley, R., Characteristics of homicide-suicide in Australia: A comparison with homicide only and suicide only cases, 2015, Journal of interpersonal violence, Vol. 33 (11) 1805 – 1829, Sage, (b) Wormer, K van., The dynamics of murder-suicide in domestic situations, 2008, Brief treatment and crisis intervention, pp 274 – 282, Oxford University Press, (c) LeFevre Sillito, C., & Salari, S., Child outcomes and risk factors in US homicide-suicide, 2011, Journal of Family Violence, 26:285 – 297, Springer Science + Business Media, (d) Liem, M., & Koenraadt, F., Familicide: a comparison with spousal and child homicide by mentally disordered perpetrators, 2008, Criminal behaviour and mental health, Vol 18, issue 5, Wiley, **(e)** Liem, M., & Koenraadt, F., Filicide: a comparative study of maternal versus paternal child homicide, 2008, Criminal behaviour and mental health, 18, 166 – 176, Wiley Inter Science.

[25] Home Office, Domestic Homicide Reviews: key findings from analysis of domestic homicide reviews, December 2016.

that all cases involved a male perpetrator; mental health issues were a factor in all seven cases (NB: for George there was never a mental health diagnosis, but he did experience mental health difficulties or mental distress).

7. The following extracted data (Table 5) from the Office for National Statistics[26], is also useful to this review as it provides a baseline by which to judge the prevalence of firearms being the method for homicide. As can be seen, it is not possible to confidently identify or confirm any trend and that, despite spikes, homicides caused by licensed firearms holders has remained relatively consistent.

Table 5: Home Office data

Table 12: Number of offences currently recorded as homicide by whether a firearm was used and whether it was licensed [notes 2,4,26] - England and Wales, year ending March 2012 to year ending March 2022

	Principal method of killing was shooting by firearm				
Year	Licensed firearm	Unlicensed firearm	Unknown if licensed firearm	No firearm involved	Total homicides
Apr 2011 to Mar 2012	8	27	5	485	525
Apr 2012 to Mar 2013	3	24	2	514	543
Apr 2013 to Mar 2014	3	17	8	493	521
Apr 2014 to Mar 2015	4	12	2	486	504
Apr 2015 to Mar 2016	1	18	6	514	539
Apr 2016 to Mar 2017	2	29	1	656	688
Apr 2017 to Mar 2018	4	19	3	671	697
Apr 2018 to Mar 2019	1	26	4	612	643
Apr 2019 to Mar 2020	6	15	5	651	677
Apr 2020 to Mar 2021	2	30	3	531	566
Apr 2021 to Mar 2022	9	19	0	668	696

Source: Data set - Appendix tables: homicide in England and Wales

Note 2: As at 6 December 2022; figures are subject to revision as cases are dealt with by the police and by the courts, or as further information becomes available.

Note 4: Home Office statisticians and police forces have undertaken a review of homicide data to update suspect data, court outcomes and cancelled crimes. Totals shown in this table will not match previously published figures.

Note 26: Firearm licensing data was introduced in the Homicide Index in 2009.

[26] Office for National Statistics, Dataset: Appendix tables: homicide in England and Wales, release date 09/02/2023; Office for National Statistics

8. Research conducted by the Home Office[27] which examined 124 DHRs in the period October 2019 to the end of September 2020, found that the use of firearms, as a method for killing, accounted for 1% of homicides.

9. Other data[28] shows that as at 31 March 2022, there were: 151,218 firearm certificates on issue, a 3% decrease compared with the previous year, 522,627 shotgun certificates on issue, a 5% decrease compared with the previous year, and 539,212 people who held a firearm and or a shotgun certificate, a 5% decrease compared with the previous year. As of March 2022, data shows there were 27,390 shotguns covered by certificate in the Surrey Police area.

5.1. Explore any information that was known by agencies, services, professional, family, friends, or work colleagues, that helps us understand the quality of the adult relationship between Emma and George, but also them as individuals and independent professional people. To consider any aspects of controlling or coercive behaviour that may have been present in the relationship.

5.1.1. GP records highlight that George visited his GP Practice in 2009 and described work related stress. He then visited again in 2014 and shared he was having marital difficulties. These two episodes are the first insights known to relevant authorities that there were problems in the relationship. In themselves, they will not be uncommon issues for discussion with a GP. On both occasions no medication was prescribed but a referral on by the GP, in 2014, for specialist assessment and therapy was made, and then followed through by George. This indicates that the symptoms were not at a level that required medical management but were viewed as best treated through a talking therapy model of intervention.

5.1.2. In 2014 East Surrey Domestic Abuse Service (ESDAS) had contact with Emma, having seen the helpline number at her GP Practice. ESDAS comment on this contact '*… Emma explained that she had recently moved out of home, away from her husband, and was now paying her own rent as well as the mortgage on the home they owned where her husband was still residing … her GP had suggested she call us as she had been having some issues with anxiety and would like to access some kind of emotional support … was interested in accessing some counselling …. Emma spoke about her work schedule, highlighting that she was deputy head of a school and worked from 7.30am to 8.30pm, so finding time to access counselling would be challenging. … Emma accepted the offer of* [the worker] *going to visit her at the school she worked at the following week. Emma was however quite anxious about this as she did not want anyone to know who* [the worker] *was or where she worked. Due to this [the worker] agreed that she would not park on the school site and would call Emma from outside once she had arrived … Emma presented as a woman who was suffering from a seemingly controlling and oppressive husband, being made to feel like her quite normal and healthy responses to his abusiveness were in fact an indication of her own failings and character flaws. This is likely to have impacted her confidence, yet she maintained her ability to complete a demanding job and actively seek help from her GP, our specialist service and potentially a private counsellor. … It presents, from the limited information we hold, that Emma was starting to recognise George's behaviour as abusive, but still had a slightly distorted perspective of reality as she was questioning herself in line with his narrative, namely thinking she was being 'too sensitive' …'*. Given the separation between Emma and George in 2013 it is evident that difficulties in the relationship continued once their relationship had resumed. These notes from ESDAS help us gain a better understanding about a number of relevant issues;

- The challenges for victims that are in the earlier stages of an abusive relationship recognising what is happening, but trying to reconcile these difficulties and showing a desire to make the relationship work. Equally, the challenges for perpetrators of an abusive relationship, acknowledging their behaviours, and the impact they may have on the relationship and the harm, and upset they may be causing.

[27] Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews, September 2021, The Home Office.

[28] National statistics: Statistics on firearm and shotgun certificates, England & Wales: April 2021 - March 2022, Published 7 July 2022, National Statistics - Home Office

- The powerful, corrosive, and undermining impact that coercion can have on a victim, where power and manipulation are used as mechanisms to control the relationship and reduce the victim's autonomy.
- The discreet benefit of having posters and information in locations such as, GP Practices, that signpost people to support services.
- The challenges for professionals, particularly professional female victims of domestic abuse, voicing and acting on, troubles they may be experiencing and seeking support.

5.1.3. At around this time, coercion and control was gaining much greater traction and recognition nationally as a feature in abusive relationships. Sections 5.4 & 5.5 examine this aspect further.

5.1.4. The Police had contact with George due to the shotgun licensing process. Police records no longer exist which might help us understand whether questions were asked about the relationship between George and Emma. Their initial contact in 2012 did not reveal any information about the relationship between Emma and George. The only information ascertained at this time, through the application process, was that George was assessed to be a safe and responsible person to be granted a shotgun certificate.

5.1.5. In 2016 the Police attended a domestic dispute incident, having been called by George who had reported an assault on him by Emma. This is the first, and only, episode of reported difficulties between the two adults to the Police. The impact of this episode on George's ownership of shotguns is explored below in section 5.3, so will not be repeated here, but is one which did provide an opportunity to question the appropriateness of him being in possession of such weapons. As is examined below, the conclusion was that he was the victim of the assault and Emma was the perpetrator. Based on the narrative outlined above by ESDAS it is reasonable to argue that this was a demonstration by George of power play, by calling the Police, resulting in Emma being arrested and taken to the Police station, and then released due to no charges being brought against her at George's election; this likely had the effect of undermining Emma's confidence and character, and being an embarrassing and humiliating experience for her – especially given her professional status.

5.1.6. The assessment of both Emma and George at that time, by attending Police Officers was that Emma and George were '*… respectable professional individuals with no concerns about their ability as individuals to care …*'. Whilst this assessment at the time may have been accurate, it is worth highlighting the concept of unconscious bias – the forming of views and opinions, positively or negatively, often without thought, that affect judgements.

5.1.7. As detailed above, Surrey Children's Services were notified, however never met with Emma, George, or Lettie. On this basis, the only knowledge Children's Services had about the couple was based on referred information from the Police. No further checks were considered necessary, and therefore Surrey Children's Services knowledge about Emma and George, individually and as a couple, was confined to the notification received. The couple did not come to the attention of Children's Services again.

5.1.8. School 1 knew Emma well, given she was employed at the school between 2016 and 2022. Emma has been universally described by former colleagues as '*… a highly professional individual, who was noted as having a strong work ethic and felt a keen responsibility that she also upheld her responsibilities as a mother* ... [also] *… her charisma and ability to command a room in a positive sense ...*'.

5.1.9. A small number of Emma's former work colleagues at School 1 were aware of some difficulties in the relationship between Emma and George, noting that Emma '*… had held conversations … indicating that there was unrest in the adult relationship …*', with one former colleague stating that Emma has indicated to her '*… she understood how it felt to be controlled. This was in the context of the former colleague confiding information of her own abusive relationship …*'. Another former work colleague has since reflected that from around January 2022,' *… began to pick up indications through conversations of real tension between Emma and George. … The unrest appeared to focus around the issue of the family home. …* [which] *had undergone a lot of work over the years and it*

was apparent that there was a lot of stress surrounding George not wanting to be in the [new home] compared to their current home …'. Another former work colleague had a discussion with Emma in December 2022 where *'… Emma indicated that she wished to leave George, and divorce was discussed between Emma and George…'*. There was no suggestion of physical domestic abuse at any point in any of these interactions – which may have diverted attention away from the effects of the control and coercion that Emma was experiencing from George.

5.1.10. The sum of these views from three of Emma's former work colleagues highlights that peers of Emma were aware of some unrest in the relationship between Emma and George. Reflections from these peers, as part of the information gathering process notes; *'… The level of concern held is judged to be consistent with adults experiencing marital difficulties, with mitigating factors of high stress events – new jobs, new school for their child and new house to move to. Emma was engaging in peer-to-peer discussions in confidence with others holding similar positions. Given the unique position of a Headmistress in a school, it might be considered a strength that she had a network of colleagues with whom to 'offload' personal issues, which would be considered unprofessional to do with those who she was responsible for in terms of line management …'*. This view is legitimate and reasonable, but highlights potential barriers which are explored in section 5.5 below.

5.1.11. Information from Police witness statements has been examined to help gain an understanding about the relationship between Emma and George. Relevant extracts are set out below;

- Emma confided in one long-time friend not long before the tragic events in February 2023, noting Emma stating she could not *'… hack George being cruel anymore …'*. The friend described George *'… as being undermining of Emma, often finding fault, and picking fights/arguments for the sake of picking fights over trivial matters. The fights were not physical fights … On one occasion George could not find the nail clippers and Emma told him they were where they were always kept, and George accused her of being incompetent and moving things unnecessarily. Emma often felt like she was walking on eggshells for example, she would cook dinner and then be accused of cooking the wrong dinner. Because of Emma's work she was very busy and wanted to employ a cleaner, but George would not allow it, or help out leaving it for Emma ...'*. The friend commented on finances, being *'… surprised they sold their house in* [one area], *but George felt it made financial sense to sell it. He was financially astute and made all of the financial decisions, sometimes not telling Emma about things. All of the sale proceeds went into George's account …'*.

- Another long-time friend and former work colleague had contact with Emma in late December 2022, asking for trusted advice. When they met, Emma became tearful stating that her marriage was over and that *'… she could no longer be George's emotional punching bag …'* and that he would get cross with her, shout and be unpleasant. She detailed that her strategy for dealing with these situations was to remain calm and not to defend herself to prevent matters escalating, however this did not always work, and matters would escalate, and George would get even more cross. The arguments would mostly happen when Lettie had gone to bed. The friend recounted that Emma had stated that George had never been violent towards her, but he would be physical with objects, and slamming things down. Emma did describe one incident when George slapped Lettie, which provoked Emma to reprimand him - this is believed to have been a one-off incident and no other reports of George hitting or slapping Lettie have been provided. The long-time friend also shared Emma's concerns about separating from George, particularly about how to explain it to Lettie, custody, fulfilling the demands of her new job as a single parent, and potential (or perceived) reputational risk for her employer. The friend helpfully suggested seeking legal advice about seeking a separation but also helped Emma disentangle the overwhelming nature of the problem Emma felt faced with. Securing custody of Lettie was a concern for Emma as this was mentioned to another friend when discussing separation – she was especially concerned because of the 2016 assault incident which she felt, would not help her case.

- A former work colleague and close friend of Emma reflected about Emma but also Lettie *'... professionally Emma had never been happier; but all of the time, I got the impression that her personal life did not match this professional success. When talking, Emma would often refer to 'George just being George', which as close friends, we didn't know what this really meant until she shared her reasons a few weeks before her death ...'*. Additional reflections also included that Emma, in thinking about separating from George, was mindful about the perceived consequences on her professional role and status and that *'... she was trying to navigate a situation in which she found herself, but which was new to everyone ...'*. Lettie has been described by the former colleague and friend as *' ... a bubbly and confident child, quite used to having adults around her, and although she struggled with a transition to a new school, did begin to settle down and enjoyed netball and gymnastics ...'*.

- A long-time friend and former work colleague of George provided descriptions of George which help us understand differences in his public and private persona *'... George was permanently in a good mood and ... laughing a lot. He was always available to all his friends including their wider circle and was instrumental in arranging many of the social events and trips that they went on over the years. ... George was always the centre of proceedings throughout.* [the friend] *stated that 'I cannot think of a single thing in all of my years knowing him that would point to anything being even marginally wrong. ...'*. Another friend of George described him, again highlighting the contrast in his persona *'... a very intelligent, professional, and well-mannered person and was very socially outgoing when it came to doing things ... very generous with his friends. He did not come across as ambitious on the career front and appeared to see work as a means to do what he really enjoyed, although he always had a job throughout the time he knew him*. [the friend] *said George was very mild mannered, and could not recall ever seeing him angry ...'.*

- Up to the age of 12 years, George had lived in four different countries and been to four different schools due to his parents' work arrangements. George was described by members of Emm's family as *'... good company, quite jovial and would put on a show but* [that] *this did not come naturally to him. ...* [and that] he *seemed troubled and trapped with an anger inside. ... George would never speak about his emotions and displayed a lack of sympathy ...'*. The family member had been aware for some time of the problems in the relationship between Emma and George, and often tried to help and offer support – estimating discussing it roughly every other month. It often felt like Emma *' ... tried and tried and tried but could never win ...'* when trying to improve the relationship. George was described as *'... often dismissive of Emma's job saying that she 'was just looking after other people's kids ...'*. Only one incident of George throwing a glass of water over Emma was ever witnessed by the family member, but knew about other incidents of George getting drunk, calling Emma names, shout at her and be verbally abusive – which used to cause Emma distress. On one occasion she advised Emma to leave the family home, which she did, and stayed away for a few days until George had calmed down. The family member commented about this type of situation *'... it was classic in that whenever Emma threatened to leave, George would say that he would change and would show enough vulnerability for her to think that there was hope ...'*. During another incident in November 2022, Emma called the relative following an argument, resulting in George becoming angry, and breaking the television. Emma remained at the family home but not long after that episode, Emma stated that they were going to give the relationship until July (2023); it never became clear what they plan was after that or what they were going to do to try and rectify their issues until July 2023. In January 2023 the close family member received a lengthy email from George *'... which she took as a cry for help. There was an acknowledgement from George that Emma was leaving him, and he implored* [the family member] *to talk to Emma ...'*. The family member *'... did feel quite sympathetic towards George and saw him as someone in pain and angry rather than someone evil. ...* [and] *was worried that George could kill himself if Emma did leave*

him and she was aware of male suicides. [the family member] *did not think for one minute George would go on to murder Emma and Lettie …'* .

5.1.12. Research[29] reminds us that leaving relationships is often the riskiest time for victims of domestic abuse; this can be made even more difficult if the victims have parenting and caring responsibilities to children who live in the same house, and who are clearly totally reliant on the care they receive i.e. Lettie. We can also hypothesize that for Emma to consider leaving George during the Covid-19 pandemic period, it would have been additionally challenging given the restrictions and health implications; this is a finding supported by recent research[30].

5.1.13. The last contact Emma had with the family member was during the evening of the incident on the telephone, with Emma starting the call by saying '*…I think I need somebody to come over. He's hit me and he's punched* [the family dog] *hard in the face …'.* Her tone of voice was that of concern but not of terror, not sounding frightened for her life and not screaming for someone to come and help, it was more like she had assessed the situation and she did not feel safe. The family member described it as the same tone she had heard when Emma phoned after George smashed the television in November 2022.

5.1.14. George's father has spent time reflecting about what has happened, and has tried to make sense about George's action. Whilst in no way wanting to excuse George's actions, the family member, knowing George very well, has reflected the following points:

- '*… While George's actions were unimaginable and tragic, there were undoubtedly complex factors at play in his life and relationship with Emma that contributed to the events leading to this tragedy …'.*

- George had '*possessive tendencies*'; Emma was a significant person in his life, and the realisation of the relationship ending, may have contributed to his '*unravelling and disintegration*'. The term anomie may be suitable to use - instability or disorientation resulting from a breakdown of standards, values, or structure to one's circumstances, which in this case, may have caused George to act in the way he did. Research[31] discusses anomic suicide, with gender, marriage and divorce being a factor.

- Both Emma and George drank alcohol – it was part of their lifestyle - but George drank alcohol heavily, which undoubtedly affected him, and may have been a contributory factor to the relationship deteriorating. George was viewed by this family member as having an element of '*self-destructiveness*' about him, knowing that excessive alcohol use was bad for him, exercising little, and having a poor diet – this did little to help a healthy lifestyle. He did experience 'mental distress'.

- George has been described as '*a shy person*', bullied and discriminated against at school, and finding crowds overbearing, having a masculine mind. He would always be polite, have friends but did not enjoy social events or interactions.

[29] a) Why don't women leave abusive relationships? Women's Aid, b) Campbell JC, Webster D, Koziol-McLain J, Block C, Campbell D, Curry MA, Gary F, Glass N, McFarlane J, Sachs C, Sharps P, Ulrich Y, Wilt SA, Manganello J, Xu X, Schollenberger J, Frye V, Laughon K. Risk factors for femicide in abusive relationships: results from a multisite case control study. Am J Public Health. 2003 Jul;93(7):1089-97, c) Domestic violence, sexual assault and stalking: findings from the British Crime Survey, 2014, Home Office.

[30] Desai, R., Bandyopadhyay, S., Zafar, S., & Bradbury-Jones, C. (Accepted/In press). The experiences of post-separation survivors of domestic violence during the COVID-19 pandemic: findings from a qualitative study in the UK. Violence against Women.

[31] a) Hodwitz, O., & Frey, K., (2016) Anomic suicide: A Durkheimian analysis of European normlessness, Sociological Spectrum, 36:4, 236-254; b) Augustine J., Kposowa, Dina., Ezzat, A., & Breault, K., (2020) Marital status, sex, and suicide: new longitudinal findings and Durkheim's marital status propositions*, Sociological Spectrum, 40:2, 81-98

- George '*… 'didn't see grey' … he saw black and white … he was rigorous and clinical in his thinking … able to debate and argue … and liked to be the devil's advocate with strong opinions …'*.

- George experienced some loss of power and control when the family home in one area was sold; '*… He had used it as a renovation project, and when it was finished it was almost like an accomplishment achieved, and then he tells me he is going to sell it* [in order to be in a house closer to Emma's new job] *… the new house caused him frustrations about how it could, or could not, be improved …'*. This point has also been confirmed as an area of frustration and difficulty for George, by members of Emma's family.

- George '*… was living with his wife's job … he had no project, and* [perceived himself] *as having less status especially during, and then following, the Covid-19 pandemic and associated restrictions and changes to working habits for many … this resulted in a loss of structure to his life …'*. Lettie was attending a new school and George began to wonder about his purpose. This point too, has also been confirmed as an issue for George, by members of Emma's family, with a strong view expressed that George was often disparaging about Emma's successes and the work she did.

- Emma seeking legal advice may have triggered George to realise the finality and certainty of Emma's intentions.

5.1.15. Whilst some research[32] may suggest Covid-19 lockdowns resulted in a positive impact for some families, other research[33] indicates it having a detrimental effect. Clearly it is impossible to know with certainty the impact it had on Emma, George, and Lettie, but there is sufficient information to indicate that it was a stressful time for them, which inevitably is likely to have raised stress levels in the family home.

5.1.16. In summary, it has been possible through accounts given by friends, former work colleagues and family members, to gain a sense about Emma and George as individuals, but also a couple.

- Some friends, relatives and some former work colleagues of Emma were aware, to varying degrees, about the difficulties between Emma and George – they were aware of emotional abuse but were never certain there was any physical abuse taking place. George's friends, family and former work colleagues were much less aware and did not get to hear the same account about the relationship – with any difficulties being reduced and being described as routine ups and downs in the relationship. The perception of George's friends was that he was the main carer for Lettie – which, it appears, was almost the opposite to the truth, with Emma taking on the greater share of parenting responsibilities. Emma's family reflect that instances of abuse appear to have been scattered among good times over many years, making anything overtly serious, harder to spot or conclude that the relationship was all bad; these more positive times are likely to have contributed to Emma remaining in the relationship for the length of time she did.

- The difficulties in the adult relationship appeared to be coming to a head, with Emma seriously contemplating leaving George. Emma however expressed concern about the impact this would have on her, Lettie, her job and career, professional reputation, and finances – which it appears, may have slowed her intentions and made it much harder to follow through separating from George. Emma was also very concerned that, in separating from George, and because of the 2016 assault incident, she would not be given custody of Lettie and that this would go to George, who was reported as the victim of that assault.

[32] British families in lockdown, 8th July 2020, Leeds Trinity University.

[33] a) School closures and children's emotional and behavioural difficulties, March 2021, Nuffield Foundation, b) NSPCC: Coronavirus, mental health & wellbeing.

- Nevertheless, it appears that Emma had made a decisive plan to separate from George shortly before the events in February 2023, and had taken legal advice, which was discussed by George when he made contact with one of Emma's family members, pleading that Emma was influenced to stay.

5.2. Examine information that helps us understand the adults individual, and combined, parenting capacity.

5.2.1. A close family member has described Emma *'… as a great mum who adored Lettie so much …'*. Views gathered from family, friends and work colleagues was that Emma would undertake the majority of the parenting responsibilities.

5.2.2. As previously noted, in 2016 Police Officers described both Emma and George' *… as respectable professional individuals with no concerns about their ability as individuals to care for Lettie, who appeared healthy, well dressed, and cared for. The Officer did however express concern about the potential emotional impact on Lettie following this incident …'*.

5.2.3. From a Health Visiting perspective, Lettie was seen at a first home visit by a Health Visitor and then again at a 6 – 8-week check. Beyond this, Lettie was not brought to the 9 - 12-month developmental review, but was brought to the 27 – 30-month check. Lettie was also subject to the Universal health service offer under the Healthy Child Programme[34] and therefore not judged as in need of any additional support. This suggests that Lettie was well cared for, and had her needs met by her parents.

5.2.4. School 1 at which both Emma worked, but also Lettie attended, commented that Emma took the greater role in communicating about Lettie's need and education in comparison to George – this is not an unusual situation. Teaching staff working with Lettie describe Emma as *'... a loving and devoted mother. There is a theme of disorganisation with respect to 'out of cycle' events such as mufti days, special celebrations, or one-off requests to bring things in. Lettie was also without swimming kit or other home-based resources slightly more often than other pupils for which Emma would be contacted/chased by teachers in the same way other families were. Emma's interactions with staff are reported to be normal compared to others in the class and appropriate to our setting, with universal agreement that Emma treated them as teachers of Lettie in her role as the mother of Lettie, rather than as colleagues whom she was responsible for … In respect to Emma's parenting capacity, it is found that she was engaged with the school as a parent, alert to any developmental milestones and acted appropriately when informed. There was plenty of evidence of normal, healthy, and loving interactions between Emma and Lettie, with never a cause for concern …'*.

5.2.5. School 1 have reflected about their interactions with George and that *'… On the occasions when George collected Lettie*, [staff] *reported that these were all very normal interactions and that George showed appropriate levels of affection towards Lettie*. [One staff member observed Lettie] *displaying challenging behaviour regarding getting into the car one afternoon, with George's response being very calm and normal, not pandering to the behaviour but dealing with it appropriately and effectively through a de-escalating stance …'*. During Covid-19 lockdown's it appears that Emma was most involved in supporting Lettie to attend online lessons, with George's contributions being less visible or apparent. One staff member *'… found that he got to know the fathers of the class much better during lockdown than in a normal school year, apart from George*. Whilst the school have no evidence positively or negatively about George's parenting, they have reflected that George may not have shared the burdens created by lockdown with Emma when it came to home-schooling, noting, '… [The staff member's] *observation was that Lettie was not as well supported during lockdown as other children – a finding echoed by other members of staff …'*.

[34] Healthy Child Programme Pregnancy and the first five years of life, 2009, HM Government.

5.2.6. School 3, where Lettie attended from September 2022 have described Lettie and interactions with Emma; '*… Lettie settled quickly and seemed very happy at school although Emma had concerns about how … settling in and … academic positioning within the cohort*. [staff spoke with Emma] *several times about …* [and the] *… significant upheaval and that she* [and Lettie were not spending as much time together] *… Emma talked about planning special time together at exeat weekends and over half term breaks …'.* School 3 also commented *'… At school Lettie seemed incredibly happy*. [being] *… comfortable and eager to chat about life …* [but] *never mentioned George but talked regularly about her mother and her maternal Grandparents. The omission in conversation about George was not unusual for a child of this age. … Lettie was always clean, well presented and … uniform and belongings were organised …'.*

5.2.7. School 2, at which Emma had recently joined to work have commented that in her role Emma did not, albeit in the six months she worked them before her death, foster personal relationships with staff members, but did attend social events – no personal information has been reported as being shared, other than expressing concerns about Lettie not settling into a new school, and stress connected to having the family dog and fitting in dog walking.

5.2.8. It is entirely reasonable to conclude, given the reported information, that Lettie was not immune to the parent's difficulties in the relationship, and seeing the interactional dynamics between George and Emma. Lettie is likely to have witnessed coercion and control. This is supported by research which comments on the impact on children, the likely under-reporting by children, and challenging any assumption that children might be seen as passive bystanders in households where this is taking place[35].

5.2.9. In summary;

- The consensus view is that Emma was the most involved parent with Lettie, and that her parenting was widely regarded as very positive, loving, and caring. Limited information has been put forward that describes George's relationship with Lettie.
- The family found it hard during the Covid-19 lockdown, as did many families, but this was somewhat exacerbated by Emma's job role and her needing to attend to her work responsibilities alongside ensuring Lettie received an education.
- Lettie appeared happy, was meeting developmental milestones, and there is no information to indicate that the parental disharmony and negative relational dynamics had any overt impact on Lettie's day to day life.

5.3. Explore the quality and effectiveness of the gun licensing process e.g. initial application & assessment, renewals, weapon security, risk management, other relevant factors.

5.3.1. Given the mode of death being caused by gunshot, inevitably, questions arise about whether George should have had access to a lethal weapon, but also about the quality and effectiveness of the process which resulted in him legally owning shotguns. This is explored.

[35] a) Callaghan, J., Alexander, J. H., Sixsmith, J., & Fellin, L. C. (2018). Beyond "Witnessing": Children's Experiences of Coercive Control in Domestic Violence and Abuse. Journal of interpersonal violence, 33(10), 1551–1581. b) Stiller, A., Neubert, C., & Krieg, Y. (2021). Witnessing Intimate Partner Violence as a Child and Associated Consequences. Journal of interpersonal violence, 8862605211055147. Advance online publication.

5.3.2. In January 2012 George made an application to Surrey Police for a shotgun certificate[36]. His intentions were to use it for clay pigeon shooting and shooting game/quarry[37]. George fully completed the application form, and provided relevant details as required.

5.3.3. Guidance[38] in place at the time (non-statutory) to support Police authorities to process gun licence applications referred to 'Fitness to be Entrusted with a Firearm' which focus more on firearms[39] rather than shotguns. Nevertheless, the guidance did refer to domestic disputes, criminal associations, previous convictions, intelligence and matters of dishonesty that were to be considered before granting or renewing licences. No previous convictions were disclosed by George and none were found by the Police during their intelligence searches of Police local or national databases. The 2012 guidance made a requirement for Firearms & Explosives Licensing Units in Police authorities to establish any current or previous domestic abuse history. The application form for George indicates that a check was made of the Police Domestic Violence Unit, confirming there was no trace.

5.3.4. In relation to the medical questions at that time, guidance advised asking the following questions:

- *Do you suffer from any medical condition or disability including alcohol and drug related conditions? George responded* 'No'.
- *Have you now, or have you ever had Epilepsy?* 'George responded 'No'.
- *Have you ever attended your present or previous General Practitioner (GP) for treatment for depression or any other kind of mental nervous disorder? George responded* 'No'.

5.3.5. George provided consent for the Police to contact his GP if needed, however, at that time, it was not mandatory to contact the GP to verify information provided and a follow up would only have taken place had any concerns arisen following the answers provided on the medical section or through other enquiries; no such need arose. It has become evident that George did not disclose the 2009 episode of '*… acute personal and work-related stress …*' which has since been confirmed by the GP as on record. There are three potential reasons we can only hypothesise about; firstly, that George either forgot to mention it, or secondly; did not see it as relevant given he did not receive any treatment or prescription to help manage it, or thirdly; recognised its relevance but chose not to disclose it.

5.3.6. A referee was provided by George, which was not Emma. Surrey Police have reflected; '*… The guidance requires only one referee for a shotgun certificate application and for first time applicants they should be visited. On the 2012 application form there is not a section for referees but there is a section for a counter-signatory and their*

[36] The following definition is based on the Home Office User guide to Statistics on firearm and shotgun certificates, England and Wales: Shotgun – A smooth-bore gun (not being an air gun) which: (i) has a barrel not less than 24 inches in length and does not have any barrel with a bore exceeding 2 inches in diameter; (ii) either has no magazine or has a non-detachable magazine incapable of holding more than two cartridges; and (iii) is not a revolver gun. Other smooth-bore guns may require a firearm certificate. It is, with certain statutory exceptions, an offence for a person to possess, purchase, or acquire any shotgun without holding a shotgun certificate. A shotgun uses shotgun cartridges containing lead shot as ammunition and is typically used for clay pigeon shooting or for the control of vermin.

[37] 'Quarry' is the general term for live animals (including birds) that can be shot over land. In this context 'land' means an area that has been judged suitable. The use of different types of weapons i.e., shotgun or firearm, to kill quarry is determined by its ability to achieve a humane kill within a safe space and distance.

[38] Firearms Licensing – Licensing guidance, good practice on firearms law, and forms for applying for approvals under the law, 19/12/2012, HM Government.

[39] The following definitions is based on the Home Office User guide to Statistics on firearm and shotgun certificates, England and Wales: a) Firearm - According to the 1968 Act, a firearm means a lethal barrelled weapon of any description from which any shot, bullet or other missile with a kinetic energy of more than one joule at the muzzle of the weapon can be discharged. It includes any prohibited weapon, any component part of such a weapon and any accessory to such a weapon designed or adapted to diminish the noise or flash caused by the firing of the weapon.

details are recorded. They state they had known George for six years and signed the declaration as to the truthfulness of the information provided by George on the application form …'.

5.3.7. All new applications required a visit to the applicant's home address by the Police to assess the security arrangements for weapon storage but also to interview the applicant. This was carried out, without issue as part of the process, and storage arrangements were judged as appropriate.

5.3.8. The granting of the shotgun certificate in 2012 was compliant with the Firearms Act 1968 and the guidance in place at that time, and as such a certificate was granted in February 2012, for a period of five years until February 2017, for the possession of two shotguns. The application concluded that George was not considered to present a danger to public safety or the peace, there was no information of concern in relation to previous convictions, arrests, police call outs, evidence, or intelligence of any criminal behaviour where no charges, conviction, or other disposal outcomes resulted. Information about other factors such as associations with criminal gangs, proscribed organisations or aggressive or anti-social behaviour, evidence of reckless behaviour, loss of control were absent. Information about problems in the relationship or other domestic turmoil and financial or debt issues were also not present in 2012. George was described as having *'… a safe and responsible attitude to firearms and fully cooperated with the application process …'*.

5.3.9. During the license period, George appropriately notified Surrey Police about a change of address in 2015, but remaining in the Surrey area. During the transition to the new address George had lodged his shotguns with a local gun shop owner. Such a step was, and is still permitted practice to ensure any weapons remain secure and that there is no breach in the conditions of the certificate. George subsequently advised the Police about the house move being finalised, new security arrangements being installed and collecting the weapons (one of which remained at a gun dealers' premises to be sold). Surrey Police carried out a home visit at the new address, again to assess the security arrangements for storage of the weapons; these new details were added to the Police recording systems. This communication with the Police demonstrates George's compliance with guidance but also an open and responsible attitude to owning and storing the weapons. It also highlights Surrey Police followed due process.

5.3.10. As detailed above in section 4, in May/June 2016 the Police attended a domestic dispute between Emma and George. One of the ensuing actions as a result of that incident was that George surrendered his certificate, and a weapon was seized.

5.3.11. This incident highlights that the Police do have powers available to seize firearms[40], and when the criteria for these powers are not met, the licensed holder is asked to voluntarily surrender both weapons and certificate. As a result of this incident, the DASH assessment judged the risk level as 'standard'. Advice within the Police guidance (Domestic Abuse and Seizure of Legally Held Firearms Policy) states that in cases where the DASH risk assessment is High or Medium the attending officers must look to seize the firearms or shotguns. However, when judged as 'standard' Officers are advised *'… to take a common-sense approach to the seizing of firearms and shotguns. In all cases where the decision not to seize is taken by the attending Officers they must notify the Duty Inspector who must sanction the decision …'*. Surrey Police have reflected that the DASH process and the criminal law is framed in terms of there being a victim and perpetrator, but Officers are always conscious that the situation may be different to how it first appears. As a result of this incident in May 2016, Officers did seize one shotgun and George did surrender his certificate. In this scenario Officers clearly did view the situation with open eyes; this being demonstrated by the removal of George's shotguns' even though he was, on first sight, the victim of a domestic assault. This matter was robustly followed through by the Police. The second shotgun held on licence was with a gun dealer for repair. The gun dealer was contacted by the Police the following day and informed about

[40] Seizure of Legally Held Firearms and Certificates Policy, Surrey Police.

the circumstances and the seizure of George's gun and certificate. This meant the dealer could not return the shotgun to George in the event he attended the shop to recover the weapon. This demonstrates a thorough approach to ensuring public safety by the Police, sound decision making and a recognition about the potential for volatility in situations – despite what might be described as a relatively passive and regretful stance taken by George when discussing the incident and involving the Police.

5.3.12. As a result of the seizure, the Police Firearms Licensing Office conducted a home visit to meet with both Emma and George. Emma *'… described the matter as trivial and was surprised her husband had called the Police. She described their relationship as now being good. She had no safety concerns regarding the return of her husband's shotguns …'.* George stated he called Police *'… to impress upon his wife she should not resort to violence, and to frighten her, though he would not have done so if he had known she would have been arrested …'*. The subsequent report by the Firearms Licensing Officer concluded that Emma and George were *'… both sensible and professional and recommended George should have his shotguns and certificate returned because he could see no public safety concerns …'.* This matter was then referred via line management process, to the Police Chief Inspector for review. Surrey Police have commented on this process,' *… This is a joint Sussex and Surrey form, and it reminds the Officer of the points underpinning firearms licensing namely; protecting public safety by preventing foreseeable or avoidable harm; delivering an efficient licensing process that is proportionate, rigorous, cost effective, fair, and timely; and providing a fair and transparent service to the public …'*. The report refers to the Police's National Decision-Making Model (NDM)[41] in order to assist and structure decision making.

5.3.13. Information about the incident, the investigation and the subsequent assessment visit by the Firearms Licensing Officer was contained in the summary of information report passed to the Chief Inspector. Current risks from George were identified as low as George *'… did not have access to his shotguns and … once returned the risk would remain low. George was the victim of the assault and there was no suggestion he was ever a danger to public safety or the peace …'*. Two options were proposed for consideration by the Chief Inspector, whilst also providing a reminder about Section 30 of the Firearms Act which details that *"a certificate may be revoked if the chief officer of police has reason to believe that the holder can no longer be permitted to have a firearm or ammunition to which the certificate relates in his possession without danger to the public safety or to the peace".* The two options were firstly, returning the certificate and shotguns, or secondly, revoking the certificate and retaining the guns. The recommendation remained that the weapons and certificate be returned. The review by the Chief Inspector concluded that *'… there had been no threats or violence from George towards his wife or child. He noted George was the victim and stated there was no information suggesting Emma had access to the cabinet or shotguns neither would she have had any inclination to use a gun … The overall assessment considering all the available information and intelligence was that the risk in returning the shotguns to George was low …'*. This matter was then referred on, and upwards, to a Superintendent, to make a final decision on behalf of the Chief Constable. An extract of the rationale states *'… There is no information or intelligence that leads me to believe either party poses a future threat with firearms or that there is a risk of foreseeable harm to themselves or the public. It would be disproportionate to revoke based on this info and intelligence …'.* As a result of this episode, the shotguns and certificate were returned to George.

5.3.14. The process detailed above highlights three separate points of evaluation by Surrey Police, two of which were two ranks above that of the Firearms Licensing Officer that made the initial evaluation of risk; this therefore injected independent scrutiny but also different levels of accountability into the decision-making process. It is argued that this represents sound and rigorous decision making and one which complies with the guidance and Firearms Act 1968 when assessing the threat to the public safety and the peace. Consideration about the balance of probabilities and patterns of behaviour are relevant to note. Whilst there had been a domestic incident, George

[41] The national decision model (NDM) is a tool to assist everyone in policing and supports decision makers to structure a rationale of what they did and why, reviews decisions and actions, and promote learning, College of Policing - National Decision Model

had been named as the victim, and not the perpetrator. There was also no evidence to suggest that Emma had neither access to the shotguns or would present a risk in respect of them (it remains unknown whether Emma did, in fact, have access to the weapons given they were in the same house and it is probable that she knew where they were kept and what the security arrangements were). There were also no previous incidents of domestic dispute, or any other behaviour by George to indicate he presented a danger to public safety or the peace.

5.3.15. As noted earlier in this report, Emma worked in School 4 and there was no notification about this incident to the local authority designated officer who, in turn, might share this with the school. This gap is further explored below in section 5.4, however there is a learning point for the Police, in that they should confirm that procedurally, both investigating officers but also decision makers, ensure that where a member of the household has been involved in a domestic abuse incident and they are employed in the children's workforce, due process is followed and either the Police notify the local authority designated officer (LADO) or there is agreement that the MASH (having been notified about the incident) notifies the LADO.

5.3.16. In November 2016 George applied to renew his shotgun certificate with Surrey Police, ahead of its expiry date. This application was processed by the same Firearms Licensing Officer that interviewed and dealt with George and Emma earlier that year following the domestic abuse incident. Surrey Police have comments '*… The renewal was completed over the phone. There was no change in circumstances or suitability concerns regarding George being allowed to continue to be a shotgun certificate holder …'*. The 2016 guidance[42] refers to this process, and notes at para *11.24, '… If the grant of a certificate is not so precluded, licensing staff have to satisfy themselves that the applicant can be permitted to possess a shotgun without danger to public safety or to the peace. A home visit should always be carried out before granting a certificate to a first-time applicant. This should include an interview and consideration of their security arrangements. At renewal a risk-based assessment may indicate the need for another interview with the applicant or further enquiries about security arrangements. These enquiries may be done over the telephone or by email rather than by home visit, in accordance with the level of the risk assessment …'*. The provision in guidance does therefore allow for telephone assessments to be carried out as part of the renewal process, and on that basis the assessment by the Police at that time was that the domestic abuse incident did not justify a home visit as part of the renewal process. Given the relative proximity of the visit conducted by the Firearms Licensing Officer in June 2016 and this renewal stage, not undertaking a further home visit – as permitted in the guidance – seems reasonable and justified.

5.3.17. As a point of note, and of relevance to this key line of enquiry, new non statutory guidance[43] about the firearms licensing process was introduced by the Home Office in April 2016, some seven months before George's renewal application. This new guidance set out expectations about seeking the involvement of GPs as part of the licensing process. In terms of assessing suitability to possess a weapon, and have a certificate, the 2016 guidance refers to relevant medical conditions, and states;

- *Para 12.26: Applicants for a firearm or shotgun certificate are required to declare any relevant medical conditions on the application form. (See below the list of relevant medical conditions.) As part of the application process the police may ask some applicants to obtain and pay for a medical report to assist with their consideration of medical suitability. GPs should provide such a report normally within one month of the request. If a further medical report is required the police will pay for this.*

- *Para 12.27: Following the grant of the certificate the police will contact each certificate holder's GP to ask them to place an encoded reminder on the patient record so that the GP is aware the person is a firearm or shotgun*

[42] Guide on Firearms Licensing Law, April 2016, Home Office.

[43] Guide on firearms licensing law, April 2016, Home Office.

certificate holder. This enables the GP to inform police if they have concerns about the person's medical fitness which arise during the validity of the certificate. In most cases the GP will not have been contacted by police during the application process (as this will usually only happen if the applicant has declared a medical condition), and the letter will normally ask if the GP has concerns about the person's possession of a firearm or shotgun certificate or if they have suffered from a relevant medical condition which could affect their medical suitability. If the police require a medical report following this contact with the GP they will request and pay for the report.

- *Para 12.28: Relevant medical conditions include:*
    - *Acute Stress Reaction or an acute reaction to the stress caused by a trauma*
    - *Suicidal thoughts or self-harm*
    - *Depression or anxiety*
    - *Mania, bipolar disorder or a psychotic illness*
    - *A personality disorder*
    - *A neurological condition: for example, Multiple Sclerosis, Parkinson's or Huntington's diseases, or epilepsy*
    - *Alcohol or drug abuse*
    - *Any other mental or physical condition which may affect the safe possession of firearms or shotguns.*

- *Para 12.29: The fact that a person has received treatment in the past for certain illnesses or conditions, such as depression or stress, does not make them automatically unsuitable to possess a firearm. It is one of the factors to be considered with all other evidence relating to the applicant's character and history. In such cases, account should be taken of the latest medical opinion, and particular attention should be paid to whether this suggests if the condition is liable to recur.*

5.3.18. George did not disclose any medical issues, and as such there was no reason not to re-issue the certificate; the certificate was therefore issued in December 2016. This renewal process complied with 2016 Home Office guidance. The 2016 guidance also provided specific provision[44] for GPs *'… Following grant of the certificate the police will contact each certificate holder's GP to ask them to place an encoded reminder on the patient record so that the GP is aware the person is a firearm certificate holder. This enables the GP to inform police if they have concerns about the person's medical fitness which arise during the validity of the certificate …'*. Information submitted confirms that a code/flag was added to George's patient records by the GP Practice, and which remained in place throughout the period under review.

5.3.19. As previously referred to above, George did not disclose the 2009 episode during his initial application in 2012, and it is also evident that he did not disclose a later episode, in 2014 of *'… acute personal and work-related stress …'*, which would have been relevant to this renewal, and which also has since been confirmed by the GP as on record. Again, there are three potential reasons we can only hypothesise about; firstly, that George either forgot to mention it, or secondly; did not see it as relevant given he did not receive any treatment or prescription to help manage it, or thirdly; recognised its relevance but chose not to disclose it. In addition to not disclosing the stress during this application, there is no record of George disclosing his alcohol intake. Information submitted from the GP to this review, regarding George's new registration at the GP Practice in 2015 notes *'… self-declared he was drinking 45 units of alcohol per week. This is compared to the upper limit of safe drinking of 14 units per week and is the equivalent of just over 2 large (250ml) glasses of wine or 2-3 pints of beer daily …'*. This too is highly relevant

[44] Guide on Firearms Licensing Law, paragraph 9, Annex A: GP and Police Information Sharing Guide, April 2016, Home Office.

information. The application or renewal process at the time of the initial application or this renewal stage could do little to combat dishonesty or deceit.

5.3.20. In February 2022 George applied to renew his shotgun certificate with Surrey Police. Revised guidance issued by the Home Office[45] regarding firearms licensing came into force, as statutory guidance. The revised guidance had been issued as a result of a Prevention of Future Deaths (PFD) notice issued by HM Coroner (Surrey), following the deaths of two women in 2014, and subsequent convictions of murder, who were killed by a licensed shotgun holder. The Inquest in June 2019 and PFD ruled on two specific issues; 1) Training of Firearms Enquiry Officers and 2) GP reports being provided on all applications and renewals. These issues were recognised by the Home Office, and factored into the strengthened national guidance issued in November 2021.

5.3.21. As a direct result of the new requirement for GPs to proactively report to all applications or renewals, this caused a short delay for George's renewal in 2022. The delay prompted George to lodge his shotguns with another registered holder – had this not been done it would have resulted in George committing a criminal offence of being in possession of a shotgun without a valid certificate and which carries a maximum prison term of five years. As previously referred to, lodging shotguns with another licence holder is permitted practice and happens in a lot of cases for this very reason.

5.3.22. On this occasion George did disclose what are considered to be relevant medical conditions i.e. acute personal and work-related stress from 2009 and 2014, but also the domestic abuse incident in 2016. As in the 2016 renewal, there is no mention about his alcohol intake, and this is not referenced in the GP handover. Information provided to this review has confirmed that, although George's disclosure of an alcohol intake of 45 units per week was above the safe limits, they would not be classed as falling into a category of alcohol misuse and were therefore not shared. Nonetheless, the disclosure of relevant information prompted a Firearms Licensing Officer to visit George, rather than discuss the issues over the phone. This is positive practice and demonstrates insight and knowledge about the importance of the renewal process being a further opportunity to reassess the individual and security arrangements. The Firearms Licensing Office described George *'… as a very reasonable and personable individual. He showed him round the house and pointed out work that had been done and he was particularly proud of the garden that had recently been landscaped …'*. George was reportedly open about his work-related stress, marital difficulties, and the domestic abuse incident – advising him that *'… the previous marital difficulties had since been resolved …'*. As noted in the new statutory guidance the presence of relationship difficulties or health related matters/conditions do need to be considered but would not automatically result in a decision to remove or not grant a shotgun certificate.

5.3.23. Review of this renewal process highlights that due process was followed. New statutory guidance was followed, relevant health information was not only disclosed by the applicant but also verified by the GP, there were no current relevant health issues disclosed, relevant Police checks were completed, and a home visit conducted. On this basis, there was no reason not to re-issue the shotgun certificate, and as such it was granted in March 2022.

5.3.24. Only with the benefit of hindsight, and as a result of the tragic events in February 2023, do the issues of honesty and deceit arise. George did not disclose, as part of this renewal, that he had been prescribed Propranolol. Propranolol is a beta-blocker prescribed for hypertension and anxiety as well as for other medical issues. In direct response to the question posed to George as part of the application *'Are there any periods in the past 10 years when you have not been registered with a UK GP or have consulted medical practitioners other than your GP practice?'* – George responded 'no', which was not true. George had sought the advice of a private GP, via an online medical service and had been prescribed Propranolol in 2019, 2020, and 2021. This information was not known about by his NHS GP and therefore could not have been included in the GP response back to the Police as part of the renewal

[45] Firearms Licensing: Statutory Guidance for Chief Officers of Police, November 2021, Home Office.

procedure. As the Police point out '*… It is an assumption that the reason George used an online service was because he dd not want this information recorded on his medical record. … The police can only respond and take action when they are made aware of information and in this case, they did not know about the prescription of this drug because it was not recorded on George's medical record …Although Propranolol is prescribed for anxiety, which is one of the medical conditions required to be disclosed, it is not an automatic bar to being allowed to possess a shotgun. It is the reasons behind the anxiety, based on an informed medical opinion from his GP, which would have determined the future of his suitability to remain a shotgun certificate holder …'*.

5.3.25. Surrey Police have reflected on the discovery of this information as a result of their investigations and discussed this with the Firearms Licensing Office that had been involved in George's applications and noted, albeit with the benefit of outcome bias '*… had George's dishonesty been discovered by the Firearms & Explosives Licensing Unit they would have seized the shotguns and certificate and investigated the reason for the prescription. Subject to the outcome of that investigation would have determined whether the shotguns were revoked or returned …'*. Such a step is permitted under the 2021 Home Office guidance when there is '*evidence of dishonesty*'. It is also worthwhile pointing out that upon the disclosure of relevant health information by George and his GP in 2022, Firearms Licensing Officers did not revisit the earlier applications during which the health information would have been relevant, and consider honesty and integrity. The reasons for this are that based on the Home Office guidance that was in force at the time of either the initial application for a license or the first renewal, it is believed that George did answer the questions correctly.

5.3.26. In January 2023 George submitted an application for change of address to the new address at School 2; this information was updated on the Police database system, highlighting an effective processing of new information. The grant, renewal and change of address criteria is centred around the person rather than the location.

5.3.27. As a result of the specific circumstances of the incident which led to the deaths, School 2 is reviewing their policy and requiring any member of staff or their immediate family that live in a school owned property, to declare whether they are a licensed gun owner. This change in policy has been communicated more widely to all similar schools.

In summary, the following information has been noted:

- Across the timeframe that George held a shotgun certificate, four different versions of guidance was issued by the Home Office for Police authorities to use, more recent versions being set as statutory guidance. In each version, safeguards have become stronger, with an increased emphasis on assessing suitability including the need to consider relevant health/medical/social circumstances.

- During the timeframe under review, George made his first application for a shotgun certificate, and two subsequent renewal applications. In addition, George notified the Police, as required to do so, about changes of address, and duly followed guidance about the security arrangements for licensed weapons during those transitions.

- George was viewed as a compliant, sensible, and respectful professional by both investigating Officers and Firearms Licensing Officers, and never viewed as someone that might present a risk to public safety. The assessment of risk following a domestic dispute/abuse incident concluded that George presented a low risk to public safety.

- Some information has however come to light, which now throws aspects of that assessment about his character into question in terms of his honesty and integrity during the shotgun licensing process.

- Emma's employer did not know about George's gun licence and weapons being held within school grounds.

5.4. Examine whether the work undertaken by services in your contact was consistent with your organisation's a) professional standards, b) domestic violence policy, procedures and protocols, and c) safeguarding adults and safeguarding children's policy, procedures and protocols, d) staff welfare policy and procedures. This is applicable to universal services such as schools and health services, plus, any specialist or independent services that were used by either parent i.e. counselling services and mental health services.

5.4.1. As previously referenced, School 2 were not aware of any difficulties in the relationship between Emma and George during the short time that Emma worked for the school. They have however confirmed that they do have appropriate policies and procedures in place should any relevant issues arise, in terms of supporting staff welfare, as well as safeguarding children and adults.

5.4.2. ESDAS had two contacts with Emma – a phone call and a face-to-face meeting. ESDAS have confirmed that they had policies and procedures in place that guided their contact and involvement with Emma at the time. They have acknowledged that the ESDAS counsellor's waiting list was closed due to capacity, and so they were unable to progress the request by Emma. She was advised about this, and offered additional opportunities to meet with the Outreach worker- which is good practice and allowed Emma the opportunity for continuity, as well as receive some in-person emotional support and guidance. Emma did follow through with this offer, which indicates a keenness to seek help. The Outreach Worker arranged to meet with Emma only a few days after the phone call, '*… ensuring that Emma did not have too long to wait before the meeting as this could have meant she reconsidered her decision and decided not to meet. This again shows the worker's understanding of the importance acting upon requests for support in as timely a manner as possible to ensure the best opportunity for engagement and support is seized …*'. During the meeting Emma spoke about George not taking counselling seriously and just '*a process they had to go through*', and that it '*would all be fine*'. She also referred to George referring to her as a, '*moron*', '*too sensitive*' or a '*waste of space*'. Again, the Outreach Worker demonstrated good practice by remaining person-centred, and being alert to sensitivities such as the meeting location so as not to compromise Emma's circumstances.

5.4.3. School 1 have reflected that there was never any information that came to light that met a threshold for a referral about any safeguarding related matters – either in respect of Emma or Lettie. Emma was well supported by family, peers, and colleagues. The school have confirmed that they had the appropriate policies and procedures in place, as well as a professional welfare system through appraisal and check-in meeting – these were however not used by Emma to seek support.

5.4.4. First Community Health & Care have confirmed that Emma received services under the Universal Services programme, and was not flagged as high risk during her pregnancy. In evaluating the care offered, they comment '*… Best practice is for a Family Needs Assessment (FNA) to be carried out at first contact at home or completed by the 6–8-week check visit, this helps determine what level of service the family need from universal services. In the case of Emma, it was completed at the 6–8-week check. Questions within the FNA relate to domestic abuse; there are opportunities to indicate concerns in the many of the sections outlined in the FNA where issues can arise, such as 'home, family life and relationships; this includes 'problems with partner', 'feeling frightened' and 'violence and bullying'. Health Visiting Service recognise the importance of asking the question which is nationally recognised best practice. On the first visit with Emma, the maternal grandmother was present and therefore the routine enquiry question was not asked; this is in line with NICE guidance*[46] *…*'. They have however acknowledged that '*… in 2015 there was no Standard Operating Procedure in place within First Community or a domestic abuse policy; this is now*

[46] Domestic violence and abuse: Quality standard [QS116], Published: 29 February 2016, National Institute for Clinical Excellence.

part of the Safeguarding Teams work plan (2023-2024) …'. During a 6 – 8-week check Emma had friends staying – again, the domestic abuse question was not recorded as being asked. Future developmental checks were routinely carried out by the Nursey Nurse, in line with the Standard Operating Procedure.

5.4.5. Lettie was not brought to the 9 – 12-month developmental review and it was not standard practice to follow this up. Lettie was however brought to the 27 – 30-month check in 2017 which was conducted by a Nursery Nurse. First Community Health & Care reflect that '*… there was no entry made on the parent record regarding asking the domestic abuse question. At this time Nursery Nurses were not trained to ask the question about domestic abuse and it was not part of their role to do so; this is now recognised as a gap and in 2023 Nursery Nurses now ask the routine enquiry question. Nursery Nurses also now receive safeguarding supervision as per First Community Safeguarding Policy November 2022 …. The 27–30-month check is focused primarily on the child and entries were only made in the child's records and not the parent. Our current Adult and Children Safeguarding Policy (2022) also reflects this, and this has been raised at our August 2023 Adult and Children Safeguarding Group about how we can adopt a more think family approach to record keeping …'*. In terms of asking the parent routine domestic abuse questions, as noted above, this did not happen based on policy expectations if the child is present (which is usually likely); however, consideration will be given by the Health Visiting Team as to whether there is any other safe method of asking the question during the appointment without the knowledge of the child present.

5.4.6. As detailed above, Emma was seen twice in the Minor Injuries Unit, firstly for a dog bite and secondly for a muscle injury – on both occasions questions about domestic abuse were not asked. First Community Care & Health comment on these attendances and policy '*… At this time there was a Standard Operating Procedure with indicators of domestic abuse outlined in the appendix. Facial injuries were not included as an indicator and therefore the guidance was followed in not asking the domestic abuse question. However, it is recognised from research that over 88% of intimate partner violence victims present to emergency department with facial injuries, therefore the SOP will be updated to reflect this …'*. This is a positive development and one that is supported by research[47].

5.4.7. It is important to note that, based on the findings from research[48], victims and or survivors of domestic abuse do not always disclose incidents of abuse during the first contact with professionals and in some instances, victims need to build a trusting relationship with professionals to overcome perceived barriers. From a victim perspective, research[49] (2021), highlights three main aspects that create barriers to women disclosing domestic abuse to health care practitioners – '*… emotional (e.g., fear, embarrassment/shame, and self-blame), physical (e.g., partner's physical presence, controlling behaviour, and manipulation of professionals) and organizational (e.g., appropriateness of setting and time for disclosure). Facilitators to disclosure were interpersonal relations, safety, and validation from health care professionals …'.* Further to this, research by the Centre for Social Justice (2022)[50] reports '*… Female victims use health care services more than non-abused women and report that health care workers are the professionals they would be most likely to speak to about their abuse ... The health settings most commonly used by victims, including mental and sexual health services (including those aimed at teenagers), maternity and post-natal provision, and accident and emergency …'.*

[47] Gujrathi, R., Tang, A., Thomas, R., Park, H., Gosangi, B., Stoklosa, H,, Lewis-O'Connor, A., Seltzer, SE,, Boland, GW., Rexrode, KM., Orgill, DP., Khurana, B., Facial injury patterns in victims of intimate partner violence. Emerg Radiol. 2022 Aug; 29(4):697-707

[48] a) Heron, R.L., Eisma, M.C. & Browne, K. Barriers and Facilitators of Disclosing Domestic Violence to the UK Health Service. J Fam Viol 37, 533–543 (2022), b) Robinson, L., & Spilsbury, K., Systematic review of the perceptions and experiences of accessing health services by adult victims of domestic violence, Health & Social Care in the Community, 2007.

[49] Heron, R.L., Eisma, M.C. & Browne, K. Barriers and Facilitators of Disclosing Domestic Violence to the UK Health Service. J Fam Viol 37, 533–543 (2022).

[50] Centre for Social Justice, No honour in abuse: harnessing the health service to end domestic abuse, May 2022.

5.4.8. Surrey Police have examined the response and actions of Officers against policy and guidance in place at the time of attending the domestic assault incident in May 2016. As an initial finding, they have noted that Surrey Police Domestic Abuse Policy in place at the time was not as detailed as subsequent versions, which have been updated and strengthened given our greater knowledge and understanding about domestic abuse. Nevertheless, the Police have reviewed the Officers' actions in relation to the initial response, the focus on the victim, decision to arrest, and investigation, and can offer assurance that due process was followed alongside good practice; independent review of actions taken supports this view.

5.4.9. In terms of the initial response by Officers the investigation reports confirms that the following matters were considered and acted on by Officers

- Separating and speaking privately to all parties – be sure the victim cannot be seen or overheard.
- Assessing the need for medical assistance and gain medical consent
- Obtaining intelligence checks to inform risk/safety requirements i.e., civil injunctions, restraining orders, Domestic Violence Prevention Notice (DVPN) & firearms licence, or access to weapons.
- Obtaining & recording initial accounts/admissions.
- Victims may fear for their safety and not want to engage. Explain what you do and why you take certain actions. Reassure them and listen to their concerns.
- Asking appropriate questions to establish any course of conduct, identify and assess risk – conducting a DASH risk assessment – which was completed with George.
- Giving reassurance to the victim and children at the scene. A Child at Risk (SCARF) form was completed in respect of safeguarding Lettie and when a child comes to the attention of the Police.
- Telling the victim they are believed, and it was the right decision to seek help. Emma did not make any counter allegations and admitted the assault. George had no interest in any civil injunctions or DVPNs and repeatedly told Officers he had made a mistake in calling the Police.
- Obtaining a victim statement where a crime is committed or suspected.

5.4.10. In terms of the decision to arrest, a power of arrest did exist, and the officers chose that course of action in accordance with the policy. Surrey Police have commented *'… Although the policy does provide for occasions when an arrest may not be necessary or proportionate the overriding guidance does state that an arrest should be made where a power exists and if not, then the officer must justify the reason. … The decision making in this case was down to the officer's judgement of the situation at the time, the fact an allegation of assault had been made, and that there was a power of arrest. It allowed for the parties to be separated and for individual accounts to be further explored and for an investigation to be conducted which is stipulated within the policy. The level of investigation however is determined by the facts relevant to each individual case …'*. George expressed no wish to provide a statement, seek prosecution or support charges being brought against Emma. They note *'… the Police do have the discretion as to whether to administer a caution, but this is dependent on the victim being supportive, full admission by the suspect and the suspect being prepared to accept a caution. These factors were absent in this case. … For the above reasons, the police disposal outcome was to take no further action …. and a Detective Inspector authorised the decision to release NFA …'*. Having interviewed for the purpose of this review, the attending Officer they go on to state *'… Upon release Emma was driven home by the Officers and it was recorded that she would be given advice about Outreach domestic abuse services that provides support services for victims of domestic abuse. It is offered to all victims regardless of whether the risk is Standard, Medium, or High … (the Outreach service offers an independent, confidential listening service to anyone affected by domestic abuse). They provide advice, advocacy, and support in relation to criminal and civil law, benefits, debt, housing, safety planning, children and they can provide that support either face to face, over the phone, email or text and do not expect a victim to make any decisions about their relationships) … the attending officer, who at the time was a Police constable, recalled this incident from 2016 … and … that both he and his colleague felt conflicted by having to arrest Emma because she was a really nice person and it*

felt wrong however, an allegation of assault had been made and it was within the Domestic Abuse policy to arrest and so policy was followed … Although Emma did not make any disclosures about domestic abuse the Officer felt there may have been some underlying issues and he informed the reviewer that he and his colleague felt sorry for Emma. The offer of Outreach information may well have been because of those thoughts at that time …'.

5.4.11. The response, but also recollections by the Police, indicate insight into the relational dynamics between Emma and George at the time, and a recognition that something more was happening in the relationship that remained more hidden than the overt incident which prompted their attendance; the 'assault' by Emma was possibly symptomatic of deeper difficulties. The Police response, and 'feel' about this incident suggests a recognition about the developing knowledge of coercion and control in relationships, and that whilst George had been on the receiving end of the 'assault', the dynamics in the relationship may indicate more complicated undercurrents. In December 2015, the offence of controlling or coercive behaviour came into force through Section 76 of the Serious Crime Act 2015. Statutory guidance[51] was published at this time to assist Police and criminal justice agencies involved in the investigations of offences. At that time coercive and controlling behaviour was defined as:

- *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*
- *Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*

5.4.12. It is therefore positive that this was recognised by Officers, and that they did provide details about the outreach Service to Emma. It is also positive that Officers did not appear to discount Emma as a victim of domestic abuse simply because of her holding a professional status, nor because of there being an absence of further physical acts of harm (this finding recognizes the potential influence of outcome bias). Research[52] confirms that coercive and controlling behaviours can be just as harmful and damaging as physical acts and that often such behaviours may be a pre-cursor to physical harm. The College of Policing[53] comment on this *'… Coercive control is the most harmful form of domestic abuse and presents the greatest risk of serious injury and homicide …'.*

5.4.13. As has already been explored below/above, the seizure of George's shotguns in June 2016 was legitimate and reasonable under the circumstances, within the bounds of guidance and policy and demonstrated good practice. The Domestic Abuse and the Seizure of Legally Held Firearms policies have since been updated to reflect developing knowledge and understanding about risk assessment.

5.4.14. Surrey Children's Services have reflected that, as a result of the notification received in May 2016 regarding the Police attendance, there being no previous contact with either Emma, George or Lettie, and the risk assessment rating as low (green), contacting Emma and George would not have been proportionate. Due policy and process was followed in respect of threshold decisions, risk assessment and a decision for no further action. Review of guidance in place at the time[54] shows this to be reasonable and proportionate given the circumstances of the incident.

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[51] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework, December 2015, HM Government.

[52] Tyson, T., Coercive control and intimate partner homicide, 2020, in McMahon, M., McGorrery, P. (eds) Criminalising Coercive Control . Springer, Singapore.

[53] Domestic Abuse Risk Assessment (DARA): Rationale for development, structure & content, September 2022, College of Policing.

[54] MASH process guidance & Red/Amber/Green ratings explanatory guidance document (RAG Surrey, updated March 2016), Surrey County Council, March 2017.

5.4.15. This episode has however highlighted important learning; namely that despite there being no justification for Children's Services to become involved due to any welfare concerns for Lettie, given Emma's work role being in the children's workforce, it would have been reasonable and proportionate to have informed, and sought consultation with, the local authority designated officer (LADO). Based on statutory guidance[55] in place at the time '*…. Local authorities should … have designated a particular officer, or team of officers … to be involved in the management and oversight of allegations against people that work with children. … Arrangements should be put in place to ensure that any allegations about those who work with children are passed to the designated officer, or team of officers, without delay …'.* The LADO guidance was well embedded into both national, but also local practice and procedure in Surrey at this time, and it has not been possible to ascertain the reasons for this not happening. Had this happened, it may have prompted a follow up call by the LADO with Emma's employer; which, may have provided a further opportunity to explore the issues, albeit from a different angle.

5.4.16. The episode also highlights the Surrey Police response to a later Disclosure & Barring request by School 2 prior to her appointment, and their assessment of information declared as part of that vetting process. They note that '*… having consider all the circumstances, and the criteria set out in the DBS Quality Assurance Framework, the details of the 2016 assault were not considered relevant for the purposes of her application. The decision was based on the fact that no further action was taken in relation to the assault which is considered a 'non-conviction incident' within the framework, it was a minor assault against her husband resulting in no injury caused and there had been no further incidents reported to police. Some of the factors in determining disclosure are whether the assault was against a child or vulnerable adult and whether the individual presented a risk to the safety of those children with whom they would be responsible for. Article 8 of the Human Rights Act (Emma's right to a private life) is also engaged in the decision making. In conclusion, the minor assault by Emma against her husband, which did not result in any injury, and did not result in any other repeated incidents, did not mean she presented a risk to children, which was and is the focus and purpose of DBS checks for individuals who in this case sought employment within an education establishment …'.* This assessment of risk seems fair, reasonable, and proportionate.

5.4.17. In summary,

- There were a limited number of agencies that had contact with Emma, George, and Lettie. When they did have contact, practice was consistent with policy and procedure in place at the time. There is one exception to this, and that concerns the involvement of the local authority designated officer, for those people that are in the children's workforce. Surrey Children's Services acknowledge that the LADO was not notified.

5. 5. To consider any barriers experienced by the victim or her family/ friends/ in reporting any abuse (including any aspects of coercive and controlling behaviour) including whether the victim knew how to report domestic abuse should she have wanted to. e.g. maternal and paternal sides of the family, close friends, work colleagues

5.5.1. From review of documents and accounts provided by those that have contributed to both the Police investigation and this review, a number of barriers have been identified.

- Emma had a successful professional career, which required time and effort. Attending to the demands of her high-profile job and being a parent, did result in difficulties for her finding time to prioritise seeking support to discuss her relationship problems with ESDAS. It would not be unreasonable to conclude that this difficulty would have extended to any other later sources of professional support that Emma might have pursued, despite for example, more recent employers having a clear and confidential pathway via an Employee Assistance Programme of support.

[55] Working Together to Safeguard Children, p. 54, 2015, HM Government.

- Emma's professional career also carried status and profile; this too appears to have caused a substantive barrier for her, potentially less so in seeking support, but more so in taking action to remedy the difficulties she faced. Emma was concerned about the impact on her personally should it become public knowledge i.e. within her peer group or those that had authority over her role, and that she would somehow be perceived less favourably or capable of fulfilling her job. One example of this is being viewed as a single female parent in a role that might, more traditionally, be occupied by a couple providing a united family front. A long-time friend and former colleague reflected that it was Emma's perception that this might cause reputational risk for her employers and undermine her credibility. Of note, one of Emma's former employers consisted of a mostly female dominated management structure with a clear development programme about being a female leader. Emma also benefitted from a female Mentor to support her with transitions into different leadership roles plus specific support from the Governing Body of her most recent employment position. These measures, it seems, were not enough to help Emma overcome this perception in the earlier stages of the relationship difficulties worsening between her and George, resulting in it taking longer for her to reach a decision. However, it becomes evident from actions taken by Emma in the weeks prior to the tragic events that she did manage to overcome this perception and doubt. Emma's family have reflected on this point further '*… This raises the next important question of safe exit. … it becomes a very practical barrier but also a barrier of fear ("what will he do when I try to leave"). While it is the minority of cases that end like ours, we can imagine a lot of them don't go well at the point of leaving. Emma had expressly said in a text message to us that she felt trapped. She meant she wanted to leave but couldn't see her exit route because primarily of the practical difficulties, which were in some ways bespoke to her housing situation but likely also apply more generally to individuals on this situation to some extent (we told her we'd meet to devise a plan to get them out but that unfortunately came too late.) Improvement here requires an elevated understanding of how the danger to a victim dramatically increases at that point, knowing where to seek help (practical help) and removing barriers to seeking it. Again, if people are able to identify this type of abuse earlier in a relationship through education, perhaps the control element of the relationship will be less acute for both parties at the (earlier) point of exit …'.*

- Emma's career, work experience and job role meant she had a working knowledge about domestic abuse, coercive and controlling behaviour, child abuse & neglect, and safeguarding related matters. Emma was well informed about what action to take if she had concerns about a child's safety and welfare, but also her responsibilities towards work colleagues and staff should they disclose information of concern. This has been verified by former work colleagues that have cited her involvement in raising awareness with students through the Personal, Social, Economic & Health (PSHE) curriculum, participating in an event raising awareness about violence towards women, and importantly, her involvement and oversight of direct case work concerning a student experiencing domestic abuse and conducting a MARAC (multi-agency risk assessment) assessment.

- Section 5.4 above has already highlighted the difficulties and barriers victims of domestic abuse face when seeking support and approaching practitioners in a health setting wishing to disclose information. For Emma, it is possible that her attendances at a Minor Injuries Unit might have provided her with an opportunity to share her worries, had questions been asked (this finding recognizes the potential influence of outcome bias). Research by the Centre for Social Justice (2022)[56] reports '*… Female victims use health care services more than non-abused women and report that health care workers are the professionals they*

[56] Centre for Social Justice, No honour in abuse: harnessing the health service to end domestic abuse, May 2022.

would be most likely to speak to about their abuse ... The health settings most commonly used by victims, including mental and sexual health services (including those aimed at teenagers), maternity and post-natal provision, and accident and emergency …'.

5.6. Any issues that may be relevant arising from protected characteristics as set out in the Equality Act 2010 i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

5.6.1. The review has kept in mind the nine protected characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation).

5.6.2. Due to the age of Lettie at the time of the incident age has been considered as a protected characteristic. Whilst there is no information to indicate that Lettie was discriminated against, victimised, or harassed (as defined within the spirit of the Equality Act 2010) prior to the tragedy, there was no scope for Lettie, due to age, to act autonomously. Lettie, at seven years old was reliant on the care given by both the parents. Given the findings set out earlier in this report about the relationship problems between Emma and George it is not unreasonable to conclude that Lettie would most likely have witnessed, or heard, these parental difficulties. Research[57] confirms the harmful effects on children of witnessing and living with domestic abuse, aside from them potentially being injured during conflict *'… effects include high rates of depression and anxiety, trauma and … behavioural problems …'.* These can also impact on educational attainment, forming relationships, self-esteem, and general health and wellbeing across the life-span. The perception of children being passive bystanders, or simply witnesses, to domestic abuse should therefore be challenged. Children who live with domestic abuse are victims too. Consideration should always be given to understanding the child's daily experience of living in such an environment and the potential for emotional harm.

5.6.3. The characteristic of sex has not been discounted given the researched evidence of women being the greater victims of violent crime caused by men[58], and being the greater victims of homicide[59]. It is also relevant given Emma's career moves and becoming the first female Headteacher at a school that had always had males in the role. This highlights a potential barrier, which has been examined in previous sections of this report.

5.6.4. The characteristic of race is relevant; George was of mixed heritage, being White British & Caribbean. No explicit information has been provided which indicates that this caused any tangible recent barriers for him. However, close family members have confirmed that as a child he experienced bullying and discrimination due to his mixed heritage and skin colour. One family member also reported that George had felt, earlier on in his professional career, that his professional prospects might be limited – experiencing a 'glass ceiling' due to his mixed heritage and skin colour and being discriminated against.

5.6.5. The remaining six characteristics were considered and discounted as not being relevant to any individuals in this family.

[57] Stanley, N., Cleaver, H., & Hart, D., The impact of domestic violence, parental mental health problems, substance misuse and learning disability on parenting capacity, in, The Child's World, 2nd Edition, The comprehensive guide to assessing children in need, Edited by Horwath, J., Jessica Kingsley Publishers, 2010.

[58] Thiara, R., & Radford, L., Working with domestic violence and abuse across the life course: Understanding good practice, 2021, Jessica Kingsley.

[59] Home Office, Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews, September 2021.

5.7. Whether the impact of any organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively i.e., changes or the introduction of domestic abuse policies, training, Covid-19 etc.

5.7.1. Three agencies have put information forward in respect of organisational change over the period covered by the review, and which warrant inclusion.

5.7.2. First Community Health & Care have reflected; '*… During the period of the review 2014-2023 First Community Health first introduced the First Community Health & Care Standard Operating Procedure for Routine Enquiry (asking the question) for services working with 16 years old and above; this was authorised in August 2017 and embedded in the electronic records in September 2017. The Routine Enquiry question was already being asked by Health Visitors regularly prior to this SOP being introduced in line with NICE guidance outlined above. The SOP provided guidance surrounding the asking and recording of the Routine Enquiry Question for those over 16-year-old. The 2017 SOP stated, 'All patients who have a short episode of care provision (e.g. in clinics Minor Injury Units etc) by a clinician, should be asked the routine enquiry questions if they show any signs of domestic abuse'. … Neither of the attendances to MIU in March 2022* (by Emma) *were outlined as indicators of domestic abuse in the SOP for that time period, however this review has highlighted the importance of professionals not accepting things at face value but adopting professional curiosity and a healthy scepticism when injuries are reported. Professional curiosity and healthy scepticism were key themes that emerged from the Rapid Review along with unconscious bias. This review also raised the question of considering 'unconscious bias' in relation to domestic abuse, for example when Emma, a Head Teacher presented with an injury do we make assumptions that there are no safeguarding concerns without the professional curiosity? This is now being discussed in current Level 3 DA Training …'.* First Community Health & Care further add that '*… The 2017 Routine SOP was reviewed and revalidated in March 2022 … with the domestic abuse indicators remaining unchanged until a further review March 2023 was made prompted by an audit of Routine Enquiry completed in November 2022, and early learning from this DHR. The 2023 SOP now states that the Routine Enquiry question is asked on a monthly basis and there is a pop-up window in Emis (electronic records system) to support practitioners as a reminder …'.* First Community Health & Care have also confirmed during their Level 3 domestic abuse training staff are taught to recognise the signs of coercion and control and are provided with different examples of how to ask the routine enquiry question with patients; they encourage staff to be clear about what they are asking and why, and to provide information and examples wherever possible. There are plans in place to start streaming information about domestic abuse including coercion and control via a digital screen within the Minor Injuries waiting room which will provide information/education to patients prior to them being asked the question.

5.7.3. Surrey Police reference that, although there have been no organisational changes as such, there have been changes as a result of, for example, the Prevention of Future Deaths notice issued by the HM Surrey Coroner, and then associated changes over the timeframe regarding amended Home Office guidance and legislation for the licensing of firearms and shotguns. These have resulted in national changes to practice for Policing

5.7.4. The GP Practice, through the NHS Integrated Care Board, have commented about the impact of Covid-19 which resulted in significant changes for GP working arrangements and how patients accessed GP services. For this family, '*… it appears that the family continued to access services appropriately and were seen face to face when this clinically necessary. Emma, in particular appeared to find greater flexibility with these arrangements; on several occasions she messaged the practice electronically, was able to say when she could attend around her work commitments and was seen or phoned at a time that was pre-arranged. There is no evidence that the changes required by the pandemic adversely impacted on the medical care provided to the family. Early in the Pandemic, recognition was made of the risk posed to victims of domestic abuse by lockdown and enforced periods of time in the home environment. Responding to this, a webinar was delivered to Surrey GP Practices in September 2020 aimed at raising*

awareness of these issues and how best frontline practitioners could safely support victims at that time. This reflected national guidance issued by IRISi[60] and others …'.

5.7.5. Given the findings about George accessing private GP services and using an online prescription service, it is worth highlighting that, potentially, the use of more discreet routes by George was intensified during the Covid-19 pandemic given the greater pressures that were placed on NHS services. It is known that he accessed prescriptions prior to the pandemic and lockdowns, however it cannot be known if this then became a preferred and easier route, once he had realised it as a successful route, and which then made his access to an NHS GP less preferable. The General Medical Council (GMC) provide good practice guidance for doctors prescribing, a set of principles for remote prescribing, and advice about raising concerns if they have concerns about patient safety[61]. Given it is understood that the services were provided by an overseas doctor, it is impossible to comment on whether these guidelines were considered or not. Fundamentally however, the good practice guidance relies on a consent-based approach, with the patient needing to provide consent about information being shared with an NHS GP.

6. Lessons to be learnt

6.1. Based on chronological information, the submission of information and research, the contribution of family members, findings from the Police investigation and overall analysis, there are a number of points captured that translate into lessons to be learnt from this tragedy. These are set out below;

- An eight-stage homicide timeline model has been developed following extensive research by Dr Jane Monkton-Smith[62]. This helpfully sets out different stages which might assist with the identification and prevention of homicides. It is useful to reflect on this when examining this family. No explicit information of concern has been put forward to this review to indicate any significant concern in terms of stages 1, 2 and 3 (pre-relationship history, early relationship, and relationship) in terms of there being a dysfunctional, abusive, or controlling relationship at any point. Emma and George started their relationship in 2006. It is acknowledged that George was suffering with work related stress in 2009, but it was not until 2014 when the first recorded difficulties arise with there being a trial separation, references to relationship difficulties and help seeking behaviours by both adults. The absence of information about these earlier stages of the relationship does not mean that factors were not present – it just means that they were not identified or observed. Stages 4, 5, 6 and 7 appear more relevant (triggers, escalation, change in thinking, planning). Perpetrators feeling or perceiving that they are losing control is a dominant feature during these stages. Research has noted the following possible triggers; separation, threat of separation, imagines a separation, bankruptcy or financial ruin, physical health deteriorates in perpetrator or victim, mental health deteriorates in perpetrator or victim, redundancy, retirement, event which prompts retaliation or revenge on victim. Information points towards a steady increase in Emma's dissatisfaction and unhappiness in the relationship, and George making attempts to assert himself in the relationship. Family members have reflected about the instances of abuse seemingly being scattered among good times, and while not wanting to reduce their seriousness, they can make it harder for the victim to recognise what might be happening. There is, of course, an added level of complexity to keep in mind – the Covid-19 affect

[60] IRISi is a social enterprise established in 2017 to promote and improve the healthcare response to domestic violence and abuse.

[61] a) Good practice in prescribing and managing medicines and devices, 05/04/2021, General Medical Council, b) Remote prescribing: high level principles, undated, General Medical Council, c) Raising and acting on concerns about patient safety, 12/03/2012, General Medical Council.

[62] Dr Jane Monkton-Smith, Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide, August 2019, University of Gloucester.

– and that, due to lockdown restrictions, time together was forced onto the family, and it potentially having a deleterious affect rather than positive. Speculating about motive is unhelpful but it does leave one wondering what triggered George (stage 8, the homicide). The learning from this, for agencies and professionals, especially when working with known victims of domestic abuse and coercive control, is to be alert to significant life events, change of routine or references about separation, and how this might impact on the victim's safety and how some victims might not recognise being in an unhealthy or abusive relationship until something more significant happens.

- Research[63] reminds us that leaving relationships is often the riskiest time for victims of domestic abuse. It is often very difficult for victims of domestic abuse to leave an abusive relationship; this can be made even more difficult if the victims have parenting and caring responsibilities to children who live in the same house, and who are clearly totally reliant on the care they receive i.e. Lettie. All professionals need to be aware of the often-conflicting demands and dilemmas faced by victims and support them to find a safe route out of an abusive relationship. In this case, the impact of Covid-19 made separation even more challenging, and Emma had articulated her concerns about who might be given custody of Lettie had separation been successful; Emma was explicitly concerned about Lettie's welfare sufficiently so for it to be a factor in her decision making.

- Those professionals with responsibility for assessing incidents of domestic abuse should remain alert to unconscious bias – forming either a positive or negative bias, often unwittingly, about someone or something due to difference. Professional status or role does not exclude someone being either a victim of domestic abuse or a perpetrator of abuse.

- Children are victims of domestic abuse too; they can see, hear, or experience the effects of domestic abuse - this is now recognised in legislation through the Domestic Abuse Act 2021. Research[64] supports the view that providing safe space and opportunity for children to speak about their home life is important for all professionals to be mindful of. All professionals that work with children need to remain mindful of this, but especially those professionals that have opportunities to build trusting relationships and who can provide the time and space to speak about their home life.

- For those holding professional roles, including those with leadership responsibilities, finding a safe channel to discuss worries that are perceived as something that cannot be discussed as part of an employment relationship, is important.

- Given Emma's work role, it is evident, through information provided, that Emma was aware of how domestic abuse can impact relationships and actions that can be taken in order for victims of abuse to seek support. However, having a working knowledge about domestic abuse and sources of support Emma still felt unable to leave the relationship most likely due to the factors already outlined above. Barriers remained and assumptions should never be made about the levels of support those in positions of trust and authority may need.

- GPs considering alcohol as a relevant factor re suitability, and including this information in medical reports for new issues or renewals of gun licensing.

[63] Why don't women leave abusive relationships? Women's Aid

[64] Izaguirre, A., Cater, A., Child witnesses to intimate partner violence: Their descriptions of talking to people about the violence, 2016, Journal of Interpersonal Violence.

- The use of private GPs and online prescribing services can mean that NHS GPs are not fully informed or updated about a patient's health and medical history; whilst this may not necessarily pose a problem for the majority of the population, for those adults that are licensed gun holders it can mean that their full medical and health history is not disclosed or evaluated by an NHS GP when contacted by the Police to comment on suitability to own a lethal weapon. There appear to be no control measures in place to prevent this from happening.

- Societal expectations and gender stereotyping has influenced the way in which the emotional and mental health of men has been viewed, often resulting in issues and difficulties being undiagnosed, remaining hidden and support not being sought. In situations where emotional and mental stress may be affecting any individual (regardless of gender) it is important that all individuals are encouraged to seek support without fear of stigma.

- Notification about someone that works in the children's workforce, who is either a victim of domestic abuse, or is an offender of domestic abuse, should always go to the local authority designated officer (LADO) for assessment. Whilst in no way a reflection about Emma posing a risk to children, an opportunity did exist for another professional to view the domestic assault incident in 2016 between Emma and George from a different perspective. The role of the LADO is to consider information or incidents which may indicate that someone who works with children has;

    - behaved in a way that has harmed a child, or may have harmed a child.
    - possibly committed a criminal offence against or related to a child.
    - behaved towards a child or children in a way that indicates they may pose a risk of harm to children.
    - behaved or may have behaved in a way that indicates they may not be suitable to work with children.

7. Conclusion

7.1. This Domestic Homicide Review has examined the contact and involvement of professionals and agencies with all members of a family, who died in February 2023 as a result of gunshot by the licensed gun holder, who then took his own life. The review has benefitted from the contributions of all agencies and professionals that came into contact with family members, a Review Panel, plus members of the extended family, from both the maternal and paternal sides.

7.2. Incidents of familicide – the murder and suicide within a nuclear family – are rare. Data from other homicides and case reviews confirms that mental ill health, drug use, relationship difficulties and stress are often cited as contributory factors to such tragedies. The review has identified that illicit drug use did not feature as an issue, but alcohol use was common; the licensed gun holder suffered with, what one close family member has described as 'mental distress', but which might also be described as mental health difficulties (no diagnosis ever given). Medication, privately sourced and prescribed, was used by the licensed gun holder as a way of helping with the symptoms of this mental health difficulty, and difficulties in the relationship alongside stress were also present.

7.3. The review has examined the process of gun licensing and noted that there are a small number of deaths each year connected to licensed gun holders; however, in the majority of cases, licensed gun holders behave responsibly and do not represent a danger to themselves or others. In this case, no concerns about the issuing of a gun licence have been identified.

7.4. The review has captured a number of learning points; four significant points being; firstly, for those victims leaving an abusive relationship, it can often be the riskiest of times; secondly, perceptions about professional role and status can inhibit a victim from making timely decisions to leave abusive relationships; thirdly, children can be victims of domestic abuse; and finally, the use of private doctors and on-line prescribing services for medication can circumvent information sharing protocols with NHS GPs, and used, potentially, as a pathway to conceal the use of medication.

7.5. The Independent Chair would like to thank members of both maternal and paternal sides of the family for their contributions to the review, their patience in seeing the process through despite other challenges they faced, and their desire to seek some positive greater change out of such awful circumstances and personal tragedy.

8. Recommendations

8.1. As part of the reporting process for this review, those agencies that have contributed have identified actions for themselves and these are contained in their own single agency action plan. Responsibility for implementing, embedding, and monitoring these remains with each agency. Recommendations were made to strengthen gun licensing guidance in a relevant previous Domestic Homicide Review[65] carried out by the same Chair; it is hoped that the first four recommendations set out below will further strengthen guidance. Additional recommendations are also made:

1. The Home Office guidance Firearms Licensing: Statutory Guidance for Chief Officers of Police, February 2023, should be strengthened to include the need for applicants to declare the use of private GPs or medical consultants, and the use of on-line medication prescribing services. The strengthened guidance should then translate to Police authorities amending their application/renewal forms.

2. The Home Office guidance Firearms Licensing: Statutory Guidance for Chief Officers of Police, February 2023, should be strengthened to specifically ask applicants to declare the number of units of alcohol they consume per week (with accompanying guidance that assists the application – see, for example the NHS website: NHS Alcohol units). Where information is either provided by the applicant, or by the GP, which indicates high usage, the licensing Police authority should examine this further to assist their decision making.

3. The Home Office guidance Firearms Licensing: Statutory Guidance for Chief Officers of Police, February 2023, should be strengthened to allow licensing Police authorities the option, based on the particular circumstances of the applicant, the option to seek the views of other adult members of the applicant's household about the licence application, the holding of weapons in the home, any relevant medical conditions i.e. alcohol consumption, or additional issues including the presence of domestic abuse, coercion and control. The views of other adult members of the applicant's household should be sought separately, and not in the presence of the applicant, to avoid any fears or concerns about disclosure.

4. The Home Office guidance Firearms Licensing: Statutory Guidance for Chief Officers of Police, February 2023, should be strengthened to explicitly require an assessment of the suitability of the location of where any weapons are to be held that goes beyond assessing the arrangements for the secure physical storage of any shotgun or firearm e.g. in a property on an educational establishment grounds.

[65] Domestic Homicide Review into the deaths of Adult A, Child 1 & Child 2, and George (All of whom died in March 2020), Executive summary, Kevin Ball, Safer West Sussex Partnership.

5. Following steps already taken by the Independent Schools Bursar's Association, which has introduced a new clause in the Service Occupancy Agreement that expressly prohibits an employee (or any persons occupying any accommodation provided to them) from being in possession of, or storing, an offensive weapon and/or ammunition, the Association should formally promote annual reviews of the Agreement to check on any change to circumstances.

6. The Home Office & the Domestic Abuse Commissioner's Office should promote the Public Health England & Business in The Community Domestic Abuse Employer Toolkit. This toolkit helps employers of all sizes and sectors make a commitment to respond to the risk of domestic abuse and build an approach that ensures all employees feel supported and empowered by their workplace to deal with domestic abuse. Alongside this, the Partnership should raise the profile of this toolkit and the Employers Initiative on Domestic Abuse (http://eida.org.uk/) across all partner agencies, to raise awareness that supports all employees, regardless of role, status and position held, seek help if they are a victim of domestic abuse.

7. The Epsom & Ewell Community Safety Partnership should work with relevant agencies and other strategic partnerships to examine methods for reaching into local communities that encourage adults (particularly adult males) to seek support about emotional or mental health worries or any mental distress they may be troubled by.