South Cambridgeshire
Community Safety Partnership
Domestic Homicide Review

Executive Summary
Deborah
June 2010

Mary Mason

May 2023

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1. The Review Process

1.1 This Domestic Homicide Review was commissioned by South Cambridgeshire Community Safety Partnership in May 2022 following Robert's conviction for the murder of his wife, Deborah in 2010. The cause of death was originally recorded as a natural death from Sudden Death by Epilepsy (SUDEP).

1.2 When Robert was arrested for the murder of his fiancée, Alice, in 2017, family members contacted the police raising concerns about Deborah's death. Cambridgeshire Constabulary opened an investigation which included a full pathology examination of Deborah's brain. She had requested that her brain was donated to medical research as her father had died from motor neurone disease.

1.3 In 2018, an experts' conference was held which concluded that Deborah's death was suspicious and unnatural. Robert was charged with Deborah's murder in 2022 and was sentenced to a whole life order which on appeal was reduced to life imprisonment with a minimum term order of 35 years.

1.4 Robert does not accept either of the verdicts and maintains his innocence and his intention to a appeal both convictions.

1.5 The domestic homicide review (DHR) process began with an initial meeting of the Community Safety Partnership in March 2022 when the decision to hold a DHR was agreed. The Home Office were notified on 22 March 2022.

1.6. The first panel meeting of the DHR was held on 20 May 2022 to agree the Aims and Key Lines of Enquiry, the timetable, and any additional panel members. Dates of meetings and submission of IMRs and draft reports were also agreed. It was decided that due to the length of time since Deborah had died and the full investigation carried out by the police including their examination of police, health, and financial records, that IMRs would only be required if there was insufficient clarity or detail in the police reports.

1.7. Cambridgeshire Constabulary submitted a detailed IMR with full history. In addition, Cambridgeshire & Peterborough Coronial Service provided the original post-mortem and statements as well as information about the second investigation, including expert's reports.

1.8. The Chair spoke with the leading officers involved in the case, and to the coroner. Family and friends were informed about the DHR and sent background information leaflets. The Chair spoke directly with several family members and friends and has included information from them in this Overview Report. They have also been sent a copy of the draft report and have made comments which are also included.

1.9 To protect the identity of the family members, anonymised terms and pseudonyms have been used throughout this review to protect the identity of those involved.

1.10 Family members of Victim:

Daniel: Son, aged 18 years when Deborah died.

Chris: Son, aged 15 years when Deborah died.
Gemma: Deborah's sister
Luke: Deborah's brother
Robert: Perpetrator and husband aged 49 when Deborah died.

Friends and neighbours:
Nicola and Tony: next door neighbours of Deborah and Robert
Pauline: University friend of Deborah and bridesmaid at her wedding
Maria: University friend of Deborah

Fiancée and 2nd Victim:
Alice who died in 2016.
Alice's brother: Peter.
Fran: Friend of Alice from childhood.
Emma: friend of Alice who knew Robert.

2. Review Panel Members

The panel met three times. All members were independent of the case i.e., they had no direct management responsibility for any of the professionals involved in the case. The review panel comprised:

Name	Organisation	Designation
Jenni Brain	Cambridgeshire Constabulary	DCI within Public Protection
Tracy Brown	Cambridge University Hospitals NHS Foundation Trust	Adult Safeguarding Lead
Linda Coultrup	Safeguarding Adults (NHS Cambridgeshire and Peterborough CCG)	Named Nurse Safeguarding Adults Primary Care
Vickie Crompton	Cambridgeshire County Council	Domestic Abuse & Sexual Violence Partnership Manager
Kathryn Hawkes	South Cambridge District Council	Domestic Abuse & Sexual Violence Partnership Mger
David Savill	Cambridgeshire Constabulary	Communities Manager
Angie Stewart	Cambridge Women's Aid	Chief Executive Officer.

3.

3. Author of the Overview Report

The chair and author of this review is Mary Mason. Mary is an independent freelance consultant and has never been employed by or has any connection with the London Borough of Enfield. Mary was formerly Chief Executive of Solace Women's Aid (2003-2019), a leading Violence against Women and Girls (VAWG) charity in London. Solace has provided VAWG services for the LBE, Mary left Solace in October 2019. Mary is a qualified solicitor (non-practising) with experience in both criminal and family law. She has more than 30 years' experience in the women's, voluntary and legal sectors in supporting women and children affected by abuse. She has experience in strategic leadership and development; research about domestic abuse; planning and monitoring & evaluation of VAWG programmes. Mary has successfully adopted innovative solutions to ensure effective interventions which achieve results, increasing the quality of life of women and children.

4. Terms of Reference for the Review

4.1 The aims of this review are to:

i. Establish what lessons can be learned from Deborah's death about the way in which professionals and organisations work individually and collectively to safeguard victims.

ii. Identify how and within what timescales those lessons are to be acted on, and what is expected to change as a result.

iii. Prevent domestic homicides and related suicide by improving the way services respond to all victims of Domestic Abuse (DA) and their children, through improved understanding and intra and inter agency working.

iv. Apply those lessons to service responses including changing policies and procedures as appropriate.

v. The enquiry into and conviction of Robert for the murder of Deborah.

vi. There are two periods for the timeline of this review:

a) From records prior to her death and from June 2010 when Deborah died to July 2010 when her funeral took place.

b) From February 2017 (date of Robert's conviction for the murder of Alice, his fiancée) to February 2022 (date of Robert's conviction for the murder of Deborah).

4.2 Key lines of enquiry:

i. History of Robert and whether there were any prior DA or signs that he may have murdered Deborah and then gone on to murder his fiancée, Alice.

ii. Evidence of planning the murder of Deborah and any factors or incidents which might have led Robert to carry out this murder.

iii. Knowledge of the two children and other important family members and whether Robert considered their well-being when he planned and carried out the murder of Deborah.

iv. Did Robert continue to parent the children after he had murdered /Deborah?

v. What support the children were given by their school and other agencies after the death of their mother and then the death of Alice.

vi. Whether agency reports addressed both the 'generic issues' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this case:

a) Details of the account given by Robert for Deborah's death and whether further enquiries would have been reasonable in the circumstances.
b) Deborah's medical history, medications, and any side effects.
c) Whether a post-mortem was carried out and in what circumstances a toxicology report would have been included.
d) The relationship and dynamics between family members prior to and following Deborah's death.
e) Whether Robert had any financial problems and whether he gained financially from Deborah's death.
f) Robert's medical history including his mental and physical health.
g) Robert's work and whether his background included knowledge of drugs.
h) Any evidence that he investigated the impact of drugs on Deborah including sleeping tablets.
i) Whether Robert was given any psychiatric support following the death of Deborah.
j) If any agency had information that indicated that Deborah might have been at risk of abuse, harm, or DA and if so, whether this information was shared and if so, with which agencies or professionals?
k) How agencies supported Daniel and Chris following their mother's death and then following the opening of the investigation and subsequent guilty verdict.
l) Whether agencies were then and are now limited by lack of capacity or resources and whether at the time this had an impact on the agency's ability to investigate Deborah's death and provide support to the family.
m) Whether agencies were limited by lack of capacity or resources and whether this had an impact on the agency's ability to provide support to or to prevent Robert from perpetrating violence.
n) Whether lack of capacity or resources had an impact on any agency's ability to work effectively with other agencies.
o) Whether staff in all agencies are trained and supported in their practice around all areas of DA including coercive control.
p) Whether agencies are confident in asking questions about DA, particularly when the alleged perpetrator is present.
q) Whether agencies are confident in how to respond to DA and know how to refer cases to other agencies.

5. Summary Chronology

5.1 Robert called emergency services in June 2010 to report that he had found Deborah collapsed on the ground after returning from shopping. Their two children were out of the house, returning after emergency services arrived. Robert informed the paramedics that she had epilepsy and he had attempted CPR but had not been successful. The paramedics and police accepted that the cause of death was natural, and her body was taken to the mortuary for examination. Sudden Death by Epilepsy (SUDEP) Royal College of Pathologists Guidelines were not fully followed. The Guidelines require a full forensic examination to eliminate any other causes of death.

5.2 In 2010, Alice was on holiday in the Caribbean when her husband died in a drowning accident. She was overwhelmed by grief and on returning home she started a blog.

5.3 In late November 2010, Robert meets a young widow on a bereavement online site. They have a short relationship. Early in 2011, Robert meets Alice, a wealthy authoress, on an on-line bereavement site. He pursued her. The judge, in sentencing said to Robert 'you love bombed her'.

5.4 Alice sold her house in London in 2012 and buys a house in Cambridgeshire for Robert, herself and his two sons to live in. Sometime later Robert sells his house. In 2016, Alice goes missing, in 2017, her body is found in the cesspit, below the garage, next to their house. Robert is charged and eventually convicted of her murder.

5.5 The police opened an inquiry into Deborah's death after Robert was arrested for Alice's murder. Deborah had left her brain to medical science and an expert team was asked to carry out a full forensic examination. They reported that the death was highly likely to be non-accidental with a third party involved. They also gave timings for her death which contradicted Robert's story. They were also able to contradict Robert's version of events, including that there was no evidence he had given her CPR.

6. Conclusions

6.1 The homicide was planned and carried out by Deborah's husband, Robert, who benefitted financially from a large life insurance payment. The economic benefit is not thought to be the only or possibly the primary reason for the murders. The panel has examined other issues and considered his exercise of power and control which became an even stronger feature in the murder of Alice, presumably building on his success in not being caught for Deborah's murder.

6.2 A key reason Robert was not caught was his explanation of Alice's history of epilepsy give to the paramedics and police at the scene. They believed him, in part because of his credibility as a white middle class male. The police officer did not question his explanation for her death, missing the opportunity to collect forensics from the scene. Confirmation bias continued to play its part and by not following the SUDEP guidelines, the coroner confirmed the cause of death as SUDEP.

6.3 The second investigation, following Robert's arrest for Alice's murder, was thorough and professional. Deborah's brain was examined by experts who concluded that her death was not natural and was most likely to have been caused by a third party.

6.4 Robert continues to deny the murders and is currently seeking permission to appeal.

6.5 The panel felt it was important that any Review Board considering Robert's release on licence should be made aware of the findings of this report and seek guidance from professionals able to assess the risk he potentially poses, particularly to women in an intimate partner relationship.

7. Lessons to be Learnt

7.1 Learning has been identified in this report in three key areas:

a) In 2010 Guidelines were not in place for unexpected deaths. His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) police have reviewed their practice into the investigation of unexpected deaths. The improvements have been welcomed, and the policy is now that the police should thoroughly investigate all unexpected deaths with particular consideration to protected characteristics.

b) Coroners must always follow guidelines for SUDEP including ensuring there is a full toxicology report and exclude all other possible causes of death before resorting to SUDEP.

c) Relatives and friends spoke about how they had accepted the police, doctors, and coroner's reports. They trusted they were doing their jobs thoroughly and put their suspicions and fears to one side. They were not aware of the SUDEP diagnosis requirements. It is important that close relatives and friends are an integral part of any investigation. They should be informed about how they can bring their knowledge of the victim and perpetrator to the investigation.

7.2. The impact of the errors in this case are hugely significant as Robert went on to pursue and murder Alice. Two families have been hugely impacted by their loss of very loved mothers/sisters/aunts and daughters.

8. Recommendations

DA Commissioners Office

That this Overview report is sent to the DA Commissioner's Office to request that:

(i) The Office of the Chief Coroner is aware of this case and is satisfied that Coroners are following Guidelines on SUDIP.

(ii) The Royal College of Pathologists is aware of this case and is satisfied that pathologists are following Guidelines on SUDIP.

(iii) That discussions are held with the National Ambulance service about this case and current procedures in place regarding unexpected deaths with consideration to protected characteristics.

(iv) That warnings are flagged on bereavement and support sites to take precautions against possible perpetrators who come from all backgrounds. We recommend that anyone concerned after they, or a family member/friend meets a partner on a website, uses Clare's Law[1] to check with the police if the person has a history of domestic abuse. That where there is no evidence of previous domestic abuse the police ensure that Helpline numbers are given to the enquirer, who is reminded that the police are aware of one third of cases.

[1] https://www.met.police.uk/advice/advice-and-information/daa/domestic-abuse/alpha2/request-information-under-clares-law/

8.2 Cambridgeshire Coroner's Office

That this Overview report is sent to the Coroner's Office to assist with the new Inquest once it has been opened.

8.3 Cambridgeshire Constabulary

Cambridge Constabulary now follow procedures which were not in place in 2010. Unexpected deaths are now dealt with as outlined in the main report.

8.4. HMPPS

That this DHR Report is held as part of His Majesty's Prison and Probation Service (HMPPS) records relating to Robert and is included in the parole dossier should Robert's case be considered for Parole.

8.5 Cambridgeshire County Council

The DASV Partnership to ensure there is a service in place for Friends and Family to contact if they have concerns about Domestic Abuse

8.6. Further Recommendations

The Panel are mindful of the extreme trauma that Robert's two sons have experienced. We considered the need for specialist trauma informed counselling/therapy and noted that this should be available to victims affected by the Domestic Homicide of a family member at any point in their future lives.
Specialist therapy and counselling can currently be accessed by contacting:

Victim Support: https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service/

AAFDA: https://aafda.org.uk/

Domestic Abuse support services: for local and national support please call
The freephone, 24-hour National Domestic Abuse Helpline
0808 2000 247