

Wirral Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

'Bethany'

Date of death: May 2022

OVERVIEW REPORT

Final Version – July 2024

Chair and Author: Carol Ellwood-Clarke QPM
Support to Chair and Author: Ged McManus

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Family Tribute

STILL I RISE

You may write me down in history
With your bitter, twisted lies.
You may trod me in the very dirt
But still, like dust, I'll rise.

Does my sassiness upset you?
Why are you beset with gloom?
Cause I walk like I've got oil wells
Pumping in my living room.

Did you want to see me broken?
Bowed head and lowered eyes?
Shoulders falling down like teardrops,
Weakened by my soulful cries?

You may shoot me with your words,
You may cut me with your eyes,
You may kill me with your hatefulness,
But still, like air, I'll rise.

~ by **Maya Angelou**

1. INTRODUCTION

- 1.1 The Review Panel offers its sincere condolences to Bethany's family.
- 1.2 This report of a Domestic Homicide Review (DHR) examines how agencies responded to, and supported, Bethany, a resident of Wirral, prior to her death in May 2022. The review follows the principles within the Home Office Domestic Homicide Review Statutory Guidance (2016).¹
- 1.3 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse, whether support was accessed within the community, and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.
- 1.4 Bethany had been married to Jack for 10 years. Bethany and Jack were both employed and lived in social housing within Wirral. Bethany had two adult children, from a previous relationship. In May 2022, Bethany was found deceased at her home address. The medical cause of death was:
 - 1a Blunt Head Trauma.
- 1.5 Neither the criminal nor DHR processes have identified any knowledge or indication that agencies knew of domestic abuse within the relationship prior to Bethany's death. The report reflects agencies' involvement with Bethany and Jack, including contact during the Covid-19 pandemic. Whilst the format of the report follows the principles contained within the Home Office Statutory Guidance, the structure has been adapted to reflect the circumstances of this case. The Home Office was informed of, and agreed with, this approach.
- 1.6 Jack was arrested and charged with the murder of Bethany. In August 2023, Jack pleaded guilty to the murder of Bethany. Jack was later sentenced to life imprisonment with a minimum term of 15 years and 10 months. In sentencing Jack, the judge stated: 'It is self-evident that no sentence that I can pass can restore her life. She was a loving wife to you and a much-loved mother. Her friends and family will always mourn her death. Sometime in late 2021, you agreed to reduce your hours at work but did not tell your wife. You had a number of debts, and until this point you had been coping with your debts. But the loss of income led to debts becoming larger and unmanageable. Your stubbornness and pride meant that, rather than share your situation with her, you hid it from her and pretended nothing was wrong. You made no changes to your lifestyle,

¹ www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

pretended to go out to work full-time hours and instead funded your expenditure on cards, a bank loan and overdraft – which proved unsustainable. Debt recovery agencies began to contact you, which included warnings that bailiffs may attend. As she slept, you made your decision to kill her – in your words to save her the stress of the bailiffs - and then to take your own life. This was extreme violence and led to extensive injuries. Your increased stress was really caused by your decision to conceal the truth about your debts from your wife. I accept your remorse is genuine and that your behaviour was out of character’.

- 1.7 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.
- 1.8 It is not the purpose of this DHR to enquire into how Bethany died: that is a matter that has already been examined by a police investigation and coronial processes.

2. TIMESCALES

- 2.1 On 20 May 2022, Merseyside Police notified Wirral Community Safety Partnership of the death of Bethany. A meeting was held on 30 June 2022, where it was agreed to conduct a Domestic Homicide Review, and the Home Office was notified of the decision.
- 2.2 The first meeting of the Review Panel took place on 23 November 2023. There was a delay in the review starting due to the criminal investigation and the availability of sourcing an Independent Chair. The first and subsequent panel meetings were held virtually – contact was maintained with the panel via email and telephone calls. In total, the panel met four times.
- 2.3 The DHR covers the period from 1 January 2020 to May 2022. The start date was chosen by the Review Panel to capture relevant information in the two years prior to the death of Bethany so as to inform present and contemporary learning. All agencies were asked to consider and analyse any significant contacts prior to these dates, and this has been included within the review where relevant.
- 2.4 The Domestic Homicide Review was presented to Wirral Community Safety Partnership on 7th November 2024, and concluded on 12th December 2024, when it was sent to the Home Office.

3. CONFIDENTIALITY

- 3.1 Until the report is published, it is marked: Official Sensitive Government Security Classifications May 2018.
- 3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim and perpetrator: these were chosen by the family.
- 3.3 This table shows the age and ethnicity of the subjects of the review. No other key individuals were identified as being relevant for the review.

Name	Relationship	Age	Ethnicity
Bethany	Victim	62	White British female
Jack	Husband	52	White British male

4. TERMS OF REFERENCE

4.1 The purpose of a DHR is to:

- 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;
- 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;
- apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.
(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7)

4.2 Extensive research was undertaken with all agencies within Wirral, Merseyside, and other areas of the country where Bethany and Jack had lived. This included a search of agencies' records with Bethany's previous surnames. This resulted in no reported incidents of domestic abuse, and a lack of information/contacts held by agencies.

4.3 The panel concluded that, with so little information known about the family prior to Bethany's murder, the best approach was to set out themes for the review to examine. The panel decided on the following areas:

Domestic abuse (including coercive control).

Barriers to accessing support or being offered help regarding domestic abuse.

Finance.

Health (including mental health).

Adverse Childhood Experiences (ACEs).

Substance and/or alcohol use.

Knowledge that family, friends, and work colleagues held.

Potential impacts of the Covid-19 pandemic.

Learning from previous DHRs in Wirral.

5. METHOD

- 5.1 On 20 March 2023, Carol Ellwood-Clarke was appointed as the Independent Chair and Author for the review. She was supported in her role by Ged McManus.
- 5.2 There was a delay in the review starting due to the criminal investigation and pending Jack's trial. Following the trial, there was a further delay due to the availability of the Independent Chair.
- 5.3 On 28 March 2024, Wirral Community Safety Partnership contacted the Home Office and provided an update on the DHR. This stated that following extensive research, agencies had not identified prior knowledge of domestic abuse in the case. It was proposed that a concise overview report for the case, to capture the limited learning, would be produced. The Home Office agreed with this course of action.
- 5.4 The Chair liaised with the police to seek access to information gathered during the investigation into Bethany's death. The police provided the Chair with access to statements gathered during the criminal investigation, as well as a transcript of interviews held with Jack following the murder of Bethany. The content of these documents has been captured in the report where relevant.
- 5.5 The Chair wrote to Leeds City Council to seek access to information that they held within Children's Social Care's records. The Chair was granted physical access to these records, with relevant information being captured in the report where relevant.
- 5.6 The Chair wrote to Bethany's employer to inform them of the review. The letter contained the appropriate Home Office leaflet. Bethany's employer agreed to contribute to the review, and they met with the Chair to find out more about the review and how they could support the process. Bethany's employer agreed to hand deliver a letter from the Chair to Bethany's work colleagues, inviting them to contribute to the review. Details of their engagement is captured in Section 6 and throughout the report.
- 5.7 The Review Panel has been unable to identify any friends with whom the panel could engage. Bethany was estranged from her extended family.
- 5.8 The Chair wrote to Jack to inform him of the review. The letter was delivered by Jack's Prison Offender Manager. Jack agreed to contribute to

the review. The Chair met with Jack in the presence of his Prison Offender Manager. The meeting was held online, and information from this contact is captured in the report where relevant.

- 5.9 Thereafter, a draft overview report was produced that was discussed and refined at panel meetings before being agreed. The draft report was shared with Bethany's family.

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS, AND THE WIDER COMMUNITY

- 6.1 The Chair wrote to Bethany's son, inviting him to contribute to the review and providing him with the relevant Home Office leaflet for families. Bethany's son agreed to contribute to the review and was supported by a Victim Support Homicide Worker. The Chair met with Bethany's son, in the presence of his Victim Support Homicide Worker. Information from this meeting is captured in the report where relevant.
- 6.2 The whereabouts of Bethany's other son were not known to Bethany's family, the Chair, or any agency involved in the review.

The following information has been drawn from statements gathered during the homicide investigation.

Work Colleague 1

- 6.3 Work Colleague 1 was Bethany's supervisor and described Bethany as a happy, upbeat, outgoing person who loved to look after the residents. Bethany ran the monthly newsletter for residents. Bethany had spoken with Work Colleague 1 about domestic abuse in a previous relationship, and that she had suffered with alcoholism. Bethany told Work Colleague 1 that she was in a much happier place with Jack. She described how Bethany was proud of Jack, that he would walk her to and from work, and that Jack would call her at 2300hrs (when she was working a night shift) before he went to bed. Work Colleague 1 described how Bethany and Jack would often be seen kissing and cuddling.

Prior to Bethany's murder, Bethany had told Work Colleague 1 that she and Jack had started to sleep in separate beds, but the reason for this was not given. Work Colleague 1 stated that in the couple of weeks prior to Bethany's death, Jack seemed to have stopped walking Bethany to and from work, and that she was having to use a bus or taxi as transport.

Work Colleague 2

- 6.4 Work Colleague 2 had known Bethany for 10 months and described Bethany as a very happy and friendly person in work, who got on with everybody and loved her job. Bethany was known for constantly singing around the work place and would always offer to work extra shifts. Work Colleague 2 and Bethany would stay behind after their shifts. As a result of this, they got to know Bethany fairly well.

Bethany told Work Colleague 2 about her childhood, and that she was subjected to emotional, physical, and sexual abuse by the hands of her

mother. As a result of this abuse, Bethany had told Work Colleague 2 that she had previously turned to a life of self-neglect and sabotage and suffered from alcoholism. Bethany told Work Colleague 2 that she had overcome her addiction to alcohol and had turned to food and secret binge eating as a way of self-sabotage. Bethany told Work Colleague 2 that she had been the victim of domestic abuse with a previous partner and had suffered physical and sexual abuse. Bethany stated that this previous partner had controlled Bethany's money.

Work Colleague 2 described how Jack would walk Bethany to and from work. Work Colleague 2 described Jack as a nice man, who idolised Bethany and wanted to protect her. Work Colleague 2 stated that it was their opinion that Bethany and Jack got on great, and they were not aware of any serious issues. Work Colleague 2 stated that when Bethany spoke about Jack, her face would often light up, and she would do a little clap like a seal. They also stated that when Jack brought Bethany to work, they would take about five minutes just to say goodbye because they were constantly hugging, kissing, and telling each other that they loved them.

Work Colleague 2 described how Bethany would religiously call Jack at 2300hrs so that they could wish each other a good night. Sometimes Bethany would show Jack, through a video call, who else was working. Bethany never spoke to Work Colleague 2 about domestic abuse or other concerns in her relationship with Jack. Bethany always spoke so highly of Jack and often said that there was nothing that he would not do for her.

Work Colleague 3

- 6.5 Work Colleague 3 described Bethany as down-to-earth, caring, and easy to get on with. Bethany was a natural with the residents. Work Colleague 3 described Jack as being laid back and would not hurt a fly.

Work Colleague 4

- 6.6 Work Colleague 4 described how Jack would come and meet Bethany after work, especially in the winter months, so she did not have to walk home alone. When Jack came to pick Bethany up, Work Colleague 4 described them as being 'lovey-dovey', and they would kiss and walk down the path together. Bethany had told Work Colleague 4 that she and Jack had started to sleep in separate beds or bedrooms due to Jack's snoring.

Work Colleague 5

- 6.7 Bethany had told Work Colleague 5 that a previous partner had been controlling. No further details were given regarding how this partner was controlling. Bethany was described as being happy in her relationship with

Jack. Bethany had told Work Colleague 5 that she had previously been an 'alcoholic'.

BETHANY'S EMPLOYER

- 6.8 The Chair spoke to a senior manager from Bethany's employer. The Chair explained the review process and shared a copy of the Home Office leaflet for employers and colleagues. The senior manager agreed to speak to Bethany's work colleagues and deliver a letter from the Chair that explained the review process. In addition, the senior manager agreed to facilitate any contact and engagement with Bethany's work colleagues, including access to a mutual venue, should this be required.
- 6.9 Following the delivery of the letter, the Chair was contacted by one of Bethany's work colleagues. Their contribution has been captured within the report.
- 6.10 This was the only contact from Bethany's work colleagues. The Chair contacted the senior manager and was informed that other colleagues had declined to be involved in the review process.

JACK'S EMPLOYER

Work Colleague 6

- 6.11 Work Colleague 6 is a manager in a department store and had worked with Bethany for approximately 10 years prior to Bethany leaving. Jack worked at the same department store and had been in employment with the company for over 18 years.

Work Colleague 6 described Jack as a bright and bubbly person, who offered to help everybody; Jack had a heart of gold and overall was just a really good man. Work Colleague 6 provided further information in relation to Jack's performance and role at work. To avoid duplication, this has been captured within Section 14 of the report.

7. CONTRIBUTORS TO THE REVIEW

7.1 This table shows the agencies who provided information to the review.

Agency	Summary report
GP Practice	•
Magenta Living	•
Wirral University Teaching Hospital	•
Leeds City Council	Physical access to archived records

7.2 As part of the review process, the following agencies were written to but held no information:

Wirral Children’s Social Care
 Wirral Adult Social Care
 Merseyside Police²
 The Probation Service
 Wirral Domestic Abuse Hub
 Wirral Ways to Recovery
 Wirral Community Safety Partnership
 Wirral Community Health and Care NHS Foundation Trust
 Merseyside Fire and Rescue Service
 Cheshire and Wirral Partnership NHS Foundation
 Department for Work and Pensions

7.3 Below is a summary of contributors to the review:

7.3.1 **GP Practices (NHS Cheshire and Wirral Integrated Care Board)**

General practitioners (GPs) treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. General practice is usually the first point of contact for health concerns. General practice today has a range of clinicians and health care professionals in addition to the GP – as part of a multidisciplinary team approach – to treat and support a whole range of illnesses, provide health screening, and give health and care advice for all ages. This is enabled by care navigation, which enables practices to provide patients with the most appropriate care or response, from the right member of the practice team, including signposting or referring patients to other appropriate services based on their needs.

² This included checks using Police National Computer and Police National Database.

7.3.2 **Magenta Living**

Magenta Living is a not-for-profit housing provider: currently owning and managing nearly 13,000 properties. It is the largest affordable housing provider in Wirral, housing just under 10 per cent of Wirral's population, and also operating across the North West of England.

7.3.3 **Wirral University Teaching Hospital**

The Trust is one of the busiest and biggest acute Trusts in the North West. Comprising of three hospitals, it has the only Emergency Department in Wirral.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the Review Panel members.

Review Panel Members		
Name	Job Title	Organisation
Lynn Campbell	Head of Safeguarding and Quality	Wirral Children's Social Care
Holly Chance	Detective Inspector	Merseyside Police
Justin Danher	Head of Specialist Housing Services	Magenta Living
Carol Ellwood-Clarke	Independent Chair and Author	
Susan Fogarty	Designated Nurse, Safeguarding Adults	Wirral Place NHS Cheshire and Merseyside
Emma Graham	Business Manager	Wirral Domestic Abuse Hub
David Holmes	Project Manager/Designated Safeguarding Lead	Wirral Ways to Recovery
Gillian Jones	Operations Manager	Wirral Domestic Abuse Hub
Anthony Mullarkey	Senior Probation Officer	Probation Service North West
Ged McManus	Support to Chair and Author	
Jo Welsh	Safeguarding Adult Lead	Wirral Community Health and Care NHS Foundation Trust

8.2 The Chair of Wirral Community Safety Partnership was satisfied that the Review Panel Chair and Author was independent. In turn, the Review Panel Chair believed that there was sufficient independence and expertise on the panel to safely, and impartially, examine the events and prepare an unbiased report.

8.3 The Review Panel met four times, and the circumstances of Bethany's murder were considered in detail, with matters freely and robustly considered to ensure all possible learning could be obtained. Panel meetings were held virtually. Outside of the meetings, the Chair's queries were answered promptly via email or telephone call, and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

- 9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and Authors.
- 9.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair and Author. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – not Merseyside), in 2017, after thirty years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives.³
- 9.3 Carol was supported in her role by Ged McManus. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not Merseyside). Ged served for over thirty years in different police services in England. Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships, including Community Safety Partnership and Safeguarding Boards.
- 9.4 Between them, they have undertaken the following types of reviews: child serious case reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking DHRs. They have both completed accredited training for DHR Chairs, provided by AAFDA.
- 9.5 Both have previously completed DHRs within Wirral.

³ <https://safelives.org.uk/>

10. PARALLEL REVIEWS

- 10.1 HM Coroner for Liverpool and Wirral opened an inquest immediately after Bethany's death. Following Jack's trial and guilty plea of murder, the inquest was closed without a hearing.
- 10.2 Merseyside Police completed a criminal investigation into the circumstances of Bethany's death. Jack was arrested, charged, and convicted of Bethany's murder.
- 10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised: they should remain separate to the DHR process. There has been no indication from any agency involved in the review that the circumstances of the case have engaged their disciplinary processes.

11. EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** [for example an age group would include “over fifties” or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of

sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

- 11.2 Section 6 of the Act defines 'disability' as:
[1] A person [P] has a disability if —
[a] P has a physical or mental impairment, and
[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.⁴

- 11.3 There is nothing in agency records that indicated that any subjects of the review lacked capacity⁵ in accordance with the Mental Capacity Act 2005. Professionals applied the principle of the Mental Capacity Act 2005:

'A person must be assumed to have capacity unless it is established that he lacks capacity'.

Bethany

- 11.4 Bethany had limited contact with health professionals for routine health matters: the majority of which are not relevant for the review.
- 11.5 In 2009, Bethany had two contacts with a GP. The first related to 'insomnia' due to work pressures, and the second was documented as 'stress due to splitting with partner'. The latter contact did not relate to Jack but a previous partner of Bethany's.
- 11.6 Bethany was not known to drug and alcohol services. Statements provided by Bethany's work colleagues, documented that Bethany had stated that she had previously been an 'alcoholic'. There were no records – that

⁴ Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

⁵ The Mental Capacity Act 2005 established the following principles:

Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".

Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".

Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".

Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.

Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".

Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".

(Mental Capacity Act Guidance, Social Care Institute for Excellence)

Bethany reported to agencies – of excessive consumption of alcohol or use of drugs.

- 11.7 The Equality Act 2010 [Disability] Regulations 2010 [SI 2010/2128] specifically provide that addiction to alcohol, nicotine or any other substance [except where the addiction originally resulted from the administration of medically prescribed drugs] is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

Jack

- 11.8 Jack had limited contact with health professionals for routine health matters. The review panel did not have access to Jack's GP records because they were not released to the review, as Jack's consent had not been obtained.
- 11.9 Jack was not known to drug and alcohol services. There were no records – that Jack reported to agencies – of excessive consumption of alcohol or use of drugs.
- 11.10 All subjects of the review are white British nationals. English is their first language.

Research

- 11.11 The panel acknowledged that domestic abuse is a gendered crime, with women being more likely to be victims than men. In November 2022, the Office for National Statistics published the following data – 'Domestic abuse in England and Wales overview':⁶
- The Crime Survey for England and Wales (CSEW) estimated that 5.0% of adults (6.9% women and 3.0% men) aged 16 years and over, experienced domestic abuse in the year ending March 2022: this equates to an estimated 2.4 million adults (1.7 million women and 699,000 men).
 - Approximately 1 in 5 adults aged 16 years and over (10.4 million) had experienced domestic abuse since the age of 16 years.
 - There was no significant change in the prevalence of domestic abuse experienced by adults aged 16 to 59 years in the last year, compared with the year ending March 2020: a year largely unaffected by the coronavirus (COVID 19) pandemic and the last time the data were collected.

6

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2022>

- The number of police-recorded domestic abuse-related crimes in England and Wales increased by 7.7% compared with the previous year, to 910,980 in the year ending March 2022: this follows increases seen in previous years and may reflect increased reporting by victims.
- The Crown Prosecution Service (CPS) domestic abuse-related charging rate in England and Wales increased for the first time in four years, to 72.7% in the year ending March 2022 but remains below the year ending March 2018 (75.9%).
- The National Domestic Abuse Helpline delivered 50,791 support sessions through phone calls or live chats in the year ending March 2022: a similar number to the previous year.

12. DISEMINATION

12.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process:

- Bethany's son
- Wirral Community Safety Partnership
- All agencies that contributed to the review
- Merseyside Police and Crime Commissioner
- Domestic Abuse Commissioner

13. BACKGROUND, CHRONOLOGY AND OVERVIEW

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the subjects of the review and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies and material gathered by the police during their coronial investigations.

The Review Panel wanted to highlight that there was limited information in the below section about Bethany, which is attributed to the limited contact that Bethany had with agencies.

13.1 Bethany

13.1.1 Bethany was born in Leeds into a large family. Bethany had limited contact with her siblings and other family members. Bethany had had no contact with her mother since the late 1980s. Bethany's mother is now deceased.

13.1.2 Bethany enjoyed reading and was studying for a carer's qualification at the time of her death. Bethany loved to go to Florida on holiday. It was her favourite place and where she felt alive. Bethany last went to Florida in 2018.

13.1.3 Bethany had two children, from two previous relationships. Neither father had any involvement in their child's lives. Bethany brought the children up as a single parent. None of Bethany's family or extended family members helped her to care for her children.

13.1.4 Bethany was described in records, held by Leeds City Council, as a 'woman of extra ordinary intelligence, insight and determination'.

13.2 Jack

13.2.1 Jack was employed as an assistant manager in a local department store and had worked for the company for 18 years.

13.2.2 Bethany's son described Jack as a strange man who was almost too nice to be true. Bethany's son further stated that he thought Jack was a people pleaser who would do or say what he thought people wanted to hear.

13.2.3 Jack was not known to the police or other criminal justice agencies.

13.3 Bethany and Jack's relationship

- 13.3.1 Bethany and Jack met through work. Bethany was in another relationship when they first met, but when this ended, Bethany and Jack formed a relationship, eventually moving in together in 2009.
- 13.3.2 In April 2012, Bethany commenced a tenancy with Magenta Living.
- 13.3.3 In 2014, Bethany and Jack got married.

13.4 Events prior to the timescales of the review

- 13.4.1 In 1983, Bethany sought help from Leeds City Council Children's Social Care. This support took place in the form of parenting skills, and Bethany successfully completed a number of courses.
- 13.4.2 Over the following years, Bethany and her children were engaged with Leeds City Council Children's Social Care. In November 1990, Bethany asked for both of her children to be placed into voluntary care, as Bethany stated that she was 'unable to be an adequate parent'. Following a period of assessment, the children remained in the care of the local authority, until they reached adulthood/school leaving age. Bethany had no contact with her children until 1998.
- 13.4.3 Records from this time, documented that Bethany had told a social worker that she had 'psychological difficulties', which she attributed to a 'difficult childhood' in the form of sexual abuse from her father and stepfather. None of these matters were reported to the police. The Chair has had access to records that confirmed that Bethany received psychological counselling and professional engagement from a range of services over many years. Within those records, it was documented that Bethany blamed her mother for not protecting her from the sexual abuse that she suffered.
- 13.4.4 In August 2000, Bethany's children moved to London to live with Bethany. Bethany was married at this time. Two years later, Bethany, and her children, moved to Wirral. Bethany's son told the Chair that the reason for the move was due to debt and the fear of bailiffs. Bethany's marriage ended around 2008. Bethany's husband from this relationship is now deceased.

13.5 Events within the timescales of the review

2020

- 13.5.1 On 23 January, Bethany was seen by a GP for a routine health matter.

13.6 2021

13.6.1 In May and November, Bethany was seen by a GP for routine health matters.

The following information was provided by Jack during contact with the Chair.

13.6.2 Since October, Jack said that he had been receiving letters stating that debt collectors would be coming to the home. Jack stated that he did not seek advice from any agency on what to do about the debt but had spoken to a friend who had told him about an Individual Voluntary Arrangement (IVA).⁷

13.7 2022

The following information has been taken from statements provided during the homicide investigation.

13.7.1 In the months prior to Bethany's murder, her work colleagues had noticed a change in Bethany. Jack had stopped walking her to and from work. Bethany had described how she and Jack were sleeping in separate bedrooms, which she attributed to Jack's snoring.

13.7.2 On 15 April, Bethany had gone to a local betting shop to place a number of bets, as it was Grand National Day. On her return to work, Bethany told a colleague that a male inside the betting shop had paid her a compliment and asked to take her for a drink. Bethany was described as seeming to be happy and had gained confidence from the encounter. Bethany stated that Jack would not like the fact that another male had given her a compliment and some attention. Bethany then stated that Jack did not like it if other men looked at her when they were out.

13.7.3 In April, Bethany had two appointments with a GP for routine health matters.

13.7.4 On a date in May, Bethany was found deceased at her home address. Jack was arrested and later charged with the murder of Bethany.

⁷ [https://www.gov.uk/options-for-dealing-with-your-debts/individual-voluntary-arrangements#:~:text=An%20Individual%20Voluntary%20Arrangement%20\(%20IVA,of%20your%20assets%20than%20bankruptcy.](https://www.gov.uk/options-for-dealing-with-your-debts/individual-voluntary-arrangements#:~:text=An%20Individual%20Voluntary%20Arrangement%20(%20IVA,of%20your%20assets%20than%20bankruptcy.)

14. ANALYSIS

14.1 Domestic abuse (including coercive control).

- 14.1.1 The panel acknowledged that, although there was no indication of domestic abuse known by agencies prior to Bethany's murder, Bethany's death was a domestic homicide and therefore was evidence of domestic abuse.
- 14.1.2 As part of the research for the Domestic Homicide Review, extensive checks were undertaken across all agencies within Wirral and Merseyside. The police undertook further searches through the Police National Computer and the Police National Database against all known names of Bethany, and those of Bethany's previous partners. There were no records of domestic abuse.
- 14.1.3 Bethany's family stated that, to their knowledge, there had been no incidents of domestic abuse in Bethany's previous relationships and with Jack.
- 14.1.4 During contact with the Chair, Jack stated that, in his opinion, he had a good, happy relationship with Bethany. When asked directly, Jack denied that there had ever been any incidents of domestic abuse.
- 14.1.5 The Review Panel was aware that many incidents of domestic abuse are not reported and that, on average, victims experience 50 incidents of abuse before getting effective help.⁸ Research conducted in 2014, by Her (then) Majesty's Inspectorate of Constabulary (HMIC),⁹ found the following reasons for not reporting domestic abuse to the police:
- Fear of retaliation (45%)
 - Embarrassment or shame (40%)
 - Lack of trust or confidence in the police (30%)
 - Effect on children (30%).
- 14.1.6 The Review Panel was clear in their conclusion that whilst domestic abuse was not known by agencies, this did not negate that Bethany may have been a victim of domestic abuse.

⁸ SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives.

⁹ <https://hmicfrs.justiceinspectorates.gov.uk/publications/improving-the-police-response-to-domestic-abuse/>

14.2 Barriers to accessing support or being offered help regarding domestic abuse.

14.2.1 The Review Panel considered whether there were any indicators in this case that may have been a barrier to domestic abuse being reported or support being accessed.

14.2.2 The Victim Support report – ‘Survivor’s Justice’¹⁰ – contains the following information:

Barriers to reporting, as cited by Victim Support caseworkers

Barriers to reporting	Percentage of respondents citing barrier
Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger	52%
Fear that they would not be believed or taken seriously	42%
Fear, dislike, or distrust of the police/criminal justice system (CJS)	25%
Concern about their children and/or the involvement of social services	23%
Poor previous experience of the police/CJS	22%
Abuse normalised, not understood, or believed to be deserved	15%
Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish perpetrator	14%
Cultural or community concerns	9%
Financial concerns	7%
Housing concerns	4%
Embarrassment	3%

14.2.3 The Review Panel also considered whether Bethany’s age may have been a barrier to her reporting domestic abuse. In considering this area, the Review Panel took cognisance that Bethany was in employment and had been so for many years prior to her murder. Bethany was known to be a fit and able woman, with no ill health matters that affected her mobility. Bethany was not in receipt of any disability or other health-related benefits.

¹⁰ https://www.victimsupport.org.uk/wp-content/uploads/documents/files/VS_Survivor%E2%80%99s%20justice.pdf

- 14.2.4 In a report published by Safelives, 'Safe Later Lives',¹¹ it highlights that victims aged 61 years or over are more likely (44%) to experience abuse from an adult family member or current intimate partner than those victims under 61 years old, and on average, older victims experience abuse for twice as long before seeking help as those aged under 61, and nearly half have a disability.
- 14.2.5 In considering as to whether the case identified any potential barriers, the Review Panel took account of the research and information provided to the review by Leeds City Council. Whilst the information from Leeds City Council dated from the late 1980s and 1990s, it demonstrated that, at that time, Bethany had sought help and support from agencies for her children and her own psychological well-being.
- 14.2.6 The Review Panel was unable to reach a definitive conclusion as to whether this case identified any barriers for Bethany to report or access support for domestic abuse.
- 14.2.7 The availability of information on how to report domestic abuse, including agencies who can support domestic abuse, is captured under Term 8.

14.3 Finance.

- 14.3.1 Bethany and Jack were both in employment. Jack told the Chair that in relation to their personal finances, they each had their own bank account, and a joint savings account. Jack paid for their rent and utility bills, whilst Bethany paid for the Council Tax and food.
- 14.3.2 Jack stated that after the Covid-19 pandemic, his working hours were cut, and therefore his income was reduced. Jack stated that he had previously taken out bank loans and credit cards to support general expenditure and that when his working hours were cut, he could no longer afford to keep up the repayments; therefore, the debt spiralled. Jack stated that he kept the fact of the debt to himself, as he was embarrassed to tell Bethany. Jack told the Chair that Bethany had experienced debt in a previous relationship.
- 14.3.3 During contact with Bethany's son, he told the Chair that Bethany and a previous partner had been in debt whilst living in London, and they were visited by bailiffs. Bethany's son stated that in order to get away from the situation, the family moved to Wirral. The Review Panel understand this to have been around 2002.

¹¹ <https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse>

- 14.3.4 Jack told the Chair that since October 2021, he had been receiving letters stating that debt collectors would be coming to the home. Jack stated that he did not seek advice from any agency on what to do about the debt and that he had spoken to a friend who had told him about an Individual Voluntary Arrangement,¹² but Jack did not know how to go about this and thought it was too late anyway.
- 14.3.5 A Google search of 'individual voluntary arrangement' leads to a search result for several charities and organisations who offer advice and guidance on any aspects of debt.
- 14.3.6 Bethany's son told the Chair that Jack did not tell Bethany the truth about dropping his hours at work and that Bethany thought he had just reduced his hours by a little bit, when in fact it was by half. Bethany's son further stated that Jack would pretend to go to work and then stay at home or pretend to work a full day when he was only in for a few hours. Following the death of Bethany, her son found lots of debt letters hidden behind a wardrobe, which he did not think that Bethany had been aware of. Bethany's son was not aware of Jack's debt until after Bethany's murder.
- 14.3.7 Jack's financial matters formed part of the homicide investigation, and the information provided by Jack to the Chair concurred with the evidence gathered by the police.
- 14.3.8 In considering Bethany and Jack's financial matters, the Review Panel took cognisance of the following definitions, as detailed by the UK charity Surviving Economic Abuse:¹³

Economic abuse is a legally recognised form of domestic abuse and is defined in the Domestic Abuse Act. It often occurs in the context of intimate partner violence and involves the control of a partner or ex-partner's money and finances, as well as the things that money can buy. Economic abuse can include exerting control over income, spending, bank accounts, bills, and borrowing. It can also include controlling access to and use of things like transport and technology, to allow an individual to work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs.

Financial abuse is controlling finances, stealing money, or coercing someone into debt. Economic abuse and financial abuse involve similar

¹² <https://www.gov.uk/options-for-dealing-with-your-debts/individual-voluntary-arrangements>

¹³ <https://survivingeconomicabuse.org/about-us/what-we-do/>

Surviving Economic Abuse (SEA) is the only UK charity dedicated to raising awareness of economic abuse and transforming responses to it.

behaviours, but it is helpful to think of financial abuse as a subcategory of economic abuse.

- 14.3.9 Whilst the homicide investigation identified that Jack was in debt, there was no evidence that Bethany was aware of this debt, or that she herself had been a victim of economic or financial abuse.

14.4 Health (including mental health).

- 14.4.1 Bethany had limited contact with health professionals over the review period, which in the main, were related to minor ailments. None of these contacts raised concerns regarding their presentation or potential domestic abuse.

- 14.4.2 In 2009, prior to the timescales of this review, Bethany had two contacts with a GP. The first of these related to 'insomnia', which Bethany attributed to work pressures. The second contact was documented as 'stress due to splitting with partner'. This partner was not Jack.

- 14.4.3 The Review Panel recognised that 'stress' could be an indicator of domestic abuse. In February 2016, National Institute for Health and Care Excellence' (NICE) published Quality Standard [QS116]¹⁴ – 'Domestic Violence and Abuse'. The standard provides guidance to health professionals on:

- Asking about domestic violence and abuse.
- Response to domestic violence and abuse.
- Referral to specialist support services for people experiencing domestic violence and abuse.
- Referral to specialist support services for people perpetrating domestic violence and abuse.

Whilst the NICE guidance was not in place at the time of Bethany's contact with a GP in 2009, the Review Panel has been assured that since the implementation of the guidance, it is used, where appropriate, during appointments and contact with patients within the GP practice.

- 14.4.4 The review has not had access to Jack's GP records; therefore, analysis of Jack's health information could not be considered as part of the review.

¹⁴ <https://www.nice.org.uk/guidance/qs116>

14.5 Adverse Childhood Experiences (ACEs).

- 14.5.1 Adverse Childhood Experiences (ACEs) are defined as 'highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity'.¹⁵
- 14.5.2 The below list contains examples of ACEs:
- Physical abuse
 - Sexual abuse
 - Emotional abuse
 - Living with someone who abused drugs
 - Living with someone who abused alcohol
 - Exposure to domestic violence
 - Living with someone who has gone to prison
 - Living with someone with serious mental illness
 - Losing a parent through divorce, death, or abandonment.
- 14.5.3 In 2014, a study¹⁶ – 'Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population'¹⁷ – found that across the population sample, 47.1% of individuals reported at least one ACE. ACEs involving sexual abuse, living with someone incarcerated, or abusing drugs were most strongly associated with higher numbers of ACEs. In addition, increasing numbers of ACEs were strongly related to adverse behavioural, health, and social outcomes.
- 14.5.4 During her childhood, records held by Leeds City Council documented that Bethany had told them that, as a child, she had been a victim of sexual abuse from two adult males in her life – her father and stepfather. This information was contained in records held from the late 1980s. The sexual abuse was not known to the police or other agencies.
- 14.5.5 The records further documented that Bethany blamed her mother for the sexual abuse. During the homicide investigation, Bethany's sister provided a statement in which she described that: 'She (Bethany) didn't have any support from her family due to falling out with her mother years before over childhood trauma that had taken place. All 3 of us; Bethany,

¹⁵ <https://www.youngminds.org.uk/professional/resources/understanding-trauma-and-adversity/>

¹⁶ The study was supported by Liverpool John Moores University and National Health Service Research and Development Funds.

¹⁷ https://academic.oup.com/jpubhealth/article/36/1/81/1571104?gclid=Cj0KCQiAmKiQBhCIARIsAKtSj-nlgefEk3_VHky79_ect0TegXSAMPLr4nna49MIA5bwIOC-XuBAjN0aArOIEALw_wcB&login=false

(redacted) and myself had a traumatic upbringing and our mother was abusive to all of us, and she had no maternal instincts towards us'. In her statement, Bethany's sister stated that in later years, she was briefly in touch with Bethany by social media; however, she never met or spoke with Bethany.

- 14.5.6 As part of the evidence gathered during the homicide investigation, Bethany's work colleagues stated that she had spoken to them about her childhood, which she described as 'difficult' and that: 'her life growing up was extremely difficult and she was subjected to emotional, physical and sexual abuse by the hands of her mother'.
- 14.5.7 In 1990, Bethany made the decision to place her children into care because, in her words: 'she was unable to be an adequate parent'. Whilst these events are outside of the timescales of this review, the Review Panel concluded that Bethany's reason for doing so, may have been linked to her own childhood experiences and the impact that this had on her as an adult.
- 14.5.8 The Review Panel was clear that the information provided to the review, identified that Bethany had suffered Adverse Childhood Experiences. However, whilst this could have made her vulnerable to further abuse, the Review Panel was unable to make any definitive link to the events surrounding her murder.
- 14.5.9 The Review Panel has seen no evidence that Jack had suffered Adverse Childhood Experiences.

14.6 Substance and/or alcohol use.

- 14.6.1 Bethany and/or Jack were not known to drug and alcohol services.
- 14.6.2 There was no recording in Bethany's health records that she had discussed alcohol consumption or alcohol addiction.
- 14.6.3 The review did not have access to Jack's health records.
- 14.6.4 As part of the evidence gathered during the homicide investigation, Bethany told several work colleagues that she had previously been an 'alcoholic'. In one statement, it was documented: 'Bethany told me that she had previously turned to a life of self-neglect and sabotage and suffered from alcoholism. Bethany told me that she had a serious drink problem in the past and her health has suffered greatly because of this. Bethany stated that she had overcome her addiction to alcohol, she then turned to food and secret binge eating as a way of self-sabotage'.

- 14.6.5 Another work colleague stated that Bethany had declined to have a portion of sherry trifle at Christmas due to the alcohol content, as she (Bethany) had previously been an alcoholic.
- 14.6.6 The Review Panel has seen no evidence in agencies' records that supports the comments that Bethany made to her work colleagues. However, the Review Panel recognises that individuals may consume alcohol on a frequent basis, with levels that could be classed as harmful, but who do not seek engagement with drug and alcohol services or discuss their alcohol consumption to health professionals.

14.7 Knowledge that family, friends, and work colleagues held.

- 14.7.1 None of Bethany's family and work colleagues had any knowledge that Jack had been physically abusive towards Bethany.
- 14.7.2 Bethany's son told the Chair that Jack was clingy and possessive of Bethany, especially so in the two years or so before the murder. Bethany's son stated that he did not think that Bethany and Jack were intimate, as they slept in separate beds due to Jack's snoring. Bethany had also told work colleagues that she and Jack had started to sleep in separate beds, which she attributed to Jack's snoring.
- 14.7.3 In evidence gathered during the homicide investigation, Bethany's work colleagues stated that Jack would always walk Bethany to and from work; however, in the months prior to her murder, Bethany had started to come to work on a bus or taxi. Work colleagues described how Jack walked Bethany to the door, where they 'kissed and cuddled'. Work colleagues also stated that Bethany would call Jack at 2300 hrs on the shifts that she was working a night shift. Furthermore, they described how Bethany would, at times, be speaking to Jack on a video call and would turn the camera to show Jack who she was working with.
- 14.7.4 Work colleagues described this behaviour as 'love-dovey'. However, one colleague stated: 'On reflection, after Bethany's death I can't help but think was this Jack being courteous, or was he being over protective by walking Bethany to door or checking who she was in work with?'
- 14.7.5 Jack told the Chair that whilst he sometimes walked Bethany to work, she also sometimes got a bus or taxi. Jack denied that there had been any change in the pattern in the few months before Bethany's death.
- 14.7.6 The Review Panel discussed whether the actions by Jack could be an indicator of coercive control, as defined by Section 75 Serious Crime Act

2015. The Crown Prosecution Service Guidance on coercive control [updated 23 April 2023] states:¹⁸

Building on examples within the Statutory Guidance Framework, relevant behaviour of the suspect can include:

- isolating a person from their friends and family
- depriving them of their basic needs
- monitoring their time
- monitoring a person via online communication tools or using spyware
- using digital systems such as smart devices or social media to coerce, control, or upset the victim including posting triggering material
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep – this can be intertwined with the suspect saying it is in their best interests, and ‘rewarding’ ‘good behaviour’ e.g. with gifts
- depriving them of access to support services, such as specialist support or medical services
- repeatedly putting them down such as telling them they are worthless
- enforcing rules and activity which humiliate, degrade or dehumanise the victim
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- economic abuse including coerced debt, controlling spending/bank accounts/investments/mortgages/benefit payments
- controlling the ability to go to school or place of study
- taking wages, benefits or allowances
- threatening to hurt or kill
- threatening to harm a child
- threatening to reveal or publish private information
- threatening to hurt or physically harming a family pet
- assault
- physical intimidation e.g. blocking doors, clenching or shaking fists

¹⁸ <https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship>

- criminal damage (such as destruction of household goods)
- preventing a person from having access to transport or from working
- preventing a person from learning or using a language or making friends outside of their ethnic or cultural background
- family 'dishonour'
- reputational damage
- sexual assault or threats of sexual assault
- reproductive coercion, including restricting a victim's access to birth control, refusing to use a birth control method, forced pregnancy, forcing a victim to get an abortion, to undergo in vitro fertilisation (IVF) or other procedure, or denying access to such a procedure
- using substances such as alcohol or drugs to control a victim through dependency, or controlling their access to substances
- disclosure of sexual orientation
- disclosure of HIV status or other medical condition without consent
- limiting access to family, friends and finances
- withholding and/or destruction of the victim's immigration documents, e.g. passports and visas
- threatening to place the victim in an institution against the victim's will, e.g. care home, supported living facility, mental health facility, etc (particularly for disabled or elderly victims)

This is not an exhaustive list, and prosecutors should be aware that a suspect will often tailor the conduct to the victim, and this conduct can vary to a high degree from one person to the next. Prosecutors should consider the conduct of the suspect in each individual case to assess whether it discloses controlling or coercive behaviour. There is plainly overlap with stalking and harassment.

- 14.7.7 The Review Panel considered the information provided by family, friends, and work colleagues and concluded that there was not enough evidence to support a definitive answer as to whether Bethany had been the victim of coercive control perpetrated by Jack.
- 14.7.8 The Review Panel sought assurances of the availability of information for family and friends who have concerns about domestic abuse within a relationship. A search of 'domestic abuse support Wirral' produces links to

Wirral Council website¹⁹ – ‘itsneverokwirral’ website²⁰ – which provides links and information to local and national agencies and the Merseyside Police website.²¹

- 14.7.9 In addition, the Review Panel was informed that the Domestic Abuse Alliance²² is undertaking work, in conjunction with digital partners, to progress information and publicity campaigns through social media platforms on domestic abuse, how this can be reported, and the role of agencies to support victims of abuse.

14.8 Potential impacts of the Covid-19 pandemic.

- 14.8.1 The review period covers the months prior to, and during, the Covid-19 pandemic. At various stages across this timeframe, the Government introduced restrictions for all members of the population. Neither Bethany nor Jack was classed as being clinically extremely vulnerable.
- 14.8.2 Jack worked in retail. At the commencement of the Covid-19 pandemic, he was furloughed. Jack told the Chair that his employer reduced his working hours after the Covid-19 pandemic, which impacted on him financially. These details have been captured in 14.3.
- 14.8.3 Due to Bethany’s work, she remained in employment during the Covid-19 pandemic. The review has seen no information on any impact to Bethany’s working arrangements during the Covid-19 pandemic.
- 14.8.4 Domestic homicides did not appear to increase dramatically during the pandemic – with 163 recorded in the 12 months to 31 March 2021. This was very similar to the previous year’s figure of 152 and is in line with the 15-year average,²³ according to the Domestic Homicide Project, Vulnerability Knowledge and Practice Programme (VKPP), NPCC, College of Policing.
- 14.8.5 The Project found that the Covid-19 pandemic acted as an ‘escalator and intensifier of existing abuse’ in some instances, with victims less able to

¹⁹ <https://www.wirral.gov.uk/health-and-social-care/adult-social-care/domestic-abuse>

²⁰ <https://itsneverokwirral.org/support-for-victims-and-survivors>

This #ItsNeverOk website offers a one-stop view of services across Wirral for domestic abuse support.

²¹ <https://www.merseyside.police.uk/advice/advice-and-information/daa/domestic-abuse/support-organisations/>

²² <https://itsneverokwirral.org/who-we-are>

²³ Domestic Homicide Project, Vulnerability Knowledge and Practice Programme (VKPP), NPCC, College of Policing.

seek help due to Covid-19 restrictions. It also concluded that Covid-19 had not 'caused' domestic homicide, but it had been 'weaponised' by some abusers, as both a new tool of control over victims and – in some cases – as an excuse or defence for abuse or homicide of the victim.

- 14.8.6 The Review Panel had access to a range of information that had been produced by Wirral Domestic Abuse Services at the commencement of the Covid-19 pandemic. This included a document that was available to professionals, detailing local and national organisations and charities, their contact details, and accessibility. This document was updated on a weekly basis throughout the first stages of the Covid-19 pandemic.

14.9 Learning from previous DHRs in Wirral.

- 14.9.1 There was no learning from previous DHRs that featured in this review.

15. CONCLUSIONS

- 15.1 Bethany had been married to Jack for 10 years. In May 2022, Jack killed Bethany.
- 15.2 There were no reports of domestic abuse to the police or other agencies during their relationship prior to Bethany's murder. As a couple, Bethany and Jack were unknown to agencies in Wirral and other local authorities.
- 15.3 Bethany and Jack were both in employment. During the Covid-19 pandemic, Jack's working hours were reduced, and Jack's financial income reduced. Following the Covid-19 pandemic, Jack's financial income did not increase, and he resorted to loans and credit cards to sustain his finances, which resulted in Jack becoming in debt to numerous lenders.
- 15.4 The impact of Jack's finances was investigated during the homicide investigation and subsequent court case, which established evidence that Bethany was not aware of Jack's debt. This fact was supported by Bethany's son.
- 15.5 The Review Panel considered a range of themes whilst analysing the limited information known, and, despite the extensive research undertaken and analysis of information, the Review Panel did not identify any learning arising from this case. This was also the outcome of agencies' individual analysis of their involvement.
- 15.6 Bethany's son contributed to the review process. The Review Panel extends its thanks to him for his contribution and support during the completion of the review.

16. LEARNING IDENTIFIED

16.1 The Domestic Homicide Review Panel's Learning (Arising from panel discussions)

16.1.1 The Review Panel did not identify any learning from this review.

16.1.2 From this review, individual agencies did not identify specific learning for their agency.

17. RECOMMENDATIONS

17.1 Panel Recommendations

17.1.2 There were no panel recommendations identified.

17.2 Single Agency Recommendations

17.2.1 There were no single agency recommendations identified.

End of overview report