Domestic Homicide Review

into the death of Belinda Underwood

A report for
Herefordshire Community Safety Partnership

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Report Author

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1. Introduction

All members of the Domestic Homicide Review Panel and of the Community Safety Partnership would want to express their sympathy to the family and friends of Mrs Underwood for their loss. From all the contributions made to the review, it is clear that Mrs Underwood was well loved and respected by all who knew her, and it is clear that her loss is very keenly felt by many. The panel chair would also want to thank all local professionals from a range of organisations who have cooperated with the review and contributed in different ways to the overview report.

The purpose of a Domestic Homicide Review is to establish whether there are any lessons to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims. The review considers agency contact with Belinda and Gerald Underwood prior to her disappearance and presumed death.

This review has been conducted in line with Home Office guidance and in compliance with the relevant legislation. This guidance expects that no real identities are used in the report, in order to protect the privacy of all concerned, so the names used for the victim and perpetrator are pseudonyms. No other formal reviews are being conducted in this case.

The Herefordshire Community Safety Partnership (CSP) has agreed that no executive summary should be prepared in this case.

1.1 The Domestic Homicide Review Panel

The chair of the Domestic Homicide Review Panel and the author of the Overview Report and Executive Summary is Liz Smith, Assistant Chief Officer for West Mercia Probation Trust. Liz Smith was a member of Herefordshire Community Safety Partnership at the time the review was commenced. West Mercia Probation Trust had no involvement with either the victim or the perpetrator in this case up to the point of conviction and therefore it was agreed by the chair of the CSP that this ensured appropriate independence from the case.

1.2 Members of the Domestic Homicide Review Panel were:

Assistant Chief OfficerWest Mercia Probation Trust – CHAIR
Detective Inspector, West Mercia Police
Chief Executive Officer, West Mercia Women's Aid
Specialist Nurse Safeguarding Children, Wye Valley NHS Trust
Acute Community Services Manager, 2gether NHS Foundation Trust
Community Safety Manager, Herefordshire Council
Safeguarding Lead, Herefordshire Clinical Commissioning Group

1.3 Timescales

There was initial discussion of whether or not to conduct a Domestic Homicide Review at a meeting of the Herefordshire JCR panel in August 2012. This group is a sub-group of the CSP as well as of the Safeguarding Adult and Children's Boards, and its purpose is to gather

information and make recommendations to those respective boards. There was a delay in referral of the case due to the length of the investigation prior to the arrest and charge of Mr Underwood. All relevant agencies had researched their record of contact with Mr and Mrs Underwood at that point and had found nothing of note on record. Given the unusual circumstances of the case, where no body has ever been found, and the view that it was unlikely there would any significant learning based on the limited knowledge of the victim and perpetrator, it was recommended at that point that no review be conducted. The chair of the CSP at that point wrote to the Home Office to state this. Following advice from the Home Office and reconsideration locally, it was decided in December 2012 to recommend that a review would be conducted. The chair of the CSP wrote to the Home Office in January 2013 to confirm that decision. The completion of the report has come after the conclusion of the trial which has meant there were no legal difficulties in interviewing contributors. The report has been approved by the Home Office Quality Assurance Panel prior to publication.

1.4 Confidentiality

Prior to publication, detail of the review and findings have been kept confidential and restricted to participating professionals and their line managers.

1.5 Dissemination

At the point of publication, copies of the report will be provided to all members of the Domestic Homicide Review Panel, the Chief Executives of their agencies, the Chair of the Community Safety Partnership, and the relative and two friends of the victim, who have contributed to the review.

1.6 Terms of Reference

The terms of reference of the review, agreed by the Domestic Homicide Review Panel on 30 January 2013, were as follows:

- The review will be conducted in line with the expectations of the Home Office guidelines for Domestic Homicide Review and in line with Home Office information security expectations. For papers to be discussed at the DHR Panel and circulated between panel members full names and details will be used and papers will be marked as “Restricted”. Personal details will be redacted from any documents that are to be published.
- The review will consider whether the alleged murder should be considered to have been a one off incident or whether there had been any previous instances of domestic abuse or warning signs that Belinda Underwood could become a victim of domestic abuse
- The review will consider if any information was known by any agencies which could or should have been shared with others in order to identify and manage any potential risks towards Belinda Underwood
- The review will consider whether family, friends or any other associates of Belinda Underwood want to take part in the review and whether they were aware of any abusive behaviour from the alleged offender
- The review will consider whether there were any real or perceived barriers to Belinda Underwood or friends or associates reporting concerns about domestic abuse and whether they knew what to do if they were worried about domestic abuse

•The review will consider whether there were any opportunities for professionals to make "routine enquiries" about any experience of domestic abuse by Belinda Underwood
•The review will consider whether there is any learning about training or information sharing opportunities to promote a wider understanding of domestic abuse and relevant services available in this rural area
•Information is to be sought covering the years 2011 and 2012, but if any relevant information is revealed related to an earlier period that should be included in the review
•The review will be conducted in such a way as to avoid any potential conflict with any ongoing legal case or inquest and legal advice will be sought if necessary
•The review will consider whether there were any diversity issues of relevance to the alleged murder

2. The Review Process

2.1 Methodology

The process began with a meeting of the Herefordshire JCR panel on 30 December 2012. This group is a sub-group of the CSP as well as of the Safeguarding Adult and Children's Boards, and its purpose is to gather information and make recommendations to those respective boards. All agencies who had potentially had contact with either the perpetrator or the victim had researched their records prior to that meeting. While no agency appeared to have had any relevant contact with either the victim or the perpetrator, there was a consensus that there would be a value in conducting a formal review so as to be able to reflect on whether there was any general learning for agencies.

2.2 Contact with local agencies

West Mercia Women's Aid and West Mercia Probation confirmed that neither party had been known to their agencies at any point in the past. West Mercia Police confirmed that Mr Underwood had no previous convictions and was not previously known to them. The chair of the Domestic Homicide Review Panel met with the Senior Investigating Officer in the case.

2gether NHS Foundation Trust and Herefordshire Council (Adult Social Care) had no record of involvement with either party in the relevant period.

Herefordshire PCT (now CCG) and Wye Valley NHS trust had had contact with Mrs Underwood in the relevant period, so Independent Management Reports were commissioned from both agencies. Both agencies completed chronologies of their involvement with Mrs Underwood in the period in question. Neither chronology revealed any information that suggested any prior history of domestic abuse, even with the benefit of hindsight. The IMRs were quality assured by the Domestic Homicide Review Panel once they were completed and have been formally signed off by senior managers in those agencies.

2.3 Contact with family and friends of Belinda Underwood

Following the trial, the chair of the Domestic Homicide Review Panel contacted the only known relative and two friends of the victim to allow them to contribute to the review. They all

responded to contact from the Domestic Homicide Review chair and had telephone conversations with her.

2.4 I have received a copy of the sentencing remarks made by The Honourable Mr Justice Flaux.

4. Facts of the Case

4.1 Circumstances of the Domestic Homicide

Mrs Underwood was a woman in her sixties who disappeared from her home in a village in North Herefordshire in early 2012. She lived with her husband Gerald in a village in North Herefordshire. Belinda and Gerald Underwood first met in 1988 and married on 1st June 1996. Both had been married previously. Mr Underwood had two adult children from his previous marriage and Mrs Underwood had no children. No-one else lived in the household at the time of her disappearance. Mr Underwood reported to the police in January 2012 that his wife was missing.

From the outset, police were suspicious of apparent inconsistencies in Mr Underwood's description of events. Mrs Underwood's disappearance was treated as a murder enquiry, although initially that was not made public. During the investigation evidence came to light that Mr Underwood had been having a relationship with another woman. Police discovered that he had been spreading stories to their friends suggesting that his wife was suffering from some kind of psychological deterioration. Mrs Underwood's diaries confirmed that she suspected that her husband was having another relationship, though her husband did not admit it to her. In her diary she described her husband as "Mr Nasty", and records her feelings that he pays little attention to her.

The initial explanation given by Mr Underwood of the location and source of bloodstains found in the bedroom did not match the physical evidence and he later changed his story. After a long investigation, Mr Underwood was charged with the murder of Belinda. He pleaded not guilty, but on 2nd April 2013 he was convicted of that offence after a jury trial and given a sentence of life imprisonment.

When sentencing Mr Underwood, the judge commented:-

"….. you have been found guilty of the murder of your wife, Belinda. Since her body has never been found, only you know what became of her on the night of the 18th and 19th January 2012, and where her body is….. Belinda had discovered that you were having an affair….. You were concerned that she should not reveal the affair to other people..... on the night of the 18th/19th January..... your anger and frustration with Belinda must have boiled over. You either attacked her in the bedroom, where her blood was found..... or you attacked her elsewhere and then put her bleeding on the bed..... by whatever means you killed her, and then drove her body away in your car….. you were well able to find an isolated location to conceal her body, where even the extensive searches by the police and other local people have not found her."

Given that Mrs Underwood's body has never been found, there has been no post mortem or inquest.

4.2 Chronologies

Chronology GP (CCG IMR)			
Date	**Events, contacts and observations**	**Actions taken / decisions made**	**Comments by IMR Author**
02.03.2011	Seen in surgery.	Prescription given	No issues
15.06.2011	Seen in surgery for routine test	For repeat appointment	No issues
06.07.2011	Seen in surgery for routine test	Nothing Abnormal Detected	No issues
29.11.2011	Seen in surgery	Referred or test	No issues
30.11.2011	Test undertaken	Prescription given	No issues
05.12.2011	Rang for test results		No issues

Chronology Hereford Hospital (Wye Valley Trust IMR)			
Date	**Events, contacts and observations**	**Actions taken / decisions made**	**Comments by IMR Author**
02/12/2010	Attended A&E at Hereford Hospital sent by GP	All tests normal	No evidence of husband being present at all or contact being made for duration of stay.
08/02/2011	Attended Hereford Hospital for test which was stopped due to fatigue	Unclear as to any follow up.	

4.3 Overview of information known about the victim and the perpetrator

It was clear from all those who contributed to the Domestic Homicide Review that Mrs Underwood was a well liked, and intelligent woman, with a wide circle of friends. After a successful career as a teacher in the West Midlands, she had moved to North Herefordshire with her husband, and she was fully engaged in a range of activities in her local community. The whole community has been shocked by her murder, and the common response is that people could not believe that someone like her could become the victim of a domestic homicide.

Apart from the routine medical contacts detailed above, no other information of any relevance to the murder has come to light about either the victim or the perpetrator. There is no information that suggests that Mrs Underwood had been a victim of domestic abuse prior to her murder, either physical abuse or other types of abuse within her marriage. There is no information to suggest that Mr Underwood had ever been suspected of domestic abuse either in this marriage or previously. This was confirmed by the friends of Mrs Underwood that I spoke to, who were also of the view that she had been a very private person, so may not have been willing to disclose if there had been any previous domestic abuse.

Prior to the murder, Mr Underwood had been having a relationship with another woman, and entries in Mrs Underwood's diary confirm that she was aware of that fact. To that extent it is likely that the marriage was not a happy one in the months before the murder of Mrs Underwood. However, this does not necessarily mean that Mrs Underwood was the victim of any kind of abuse, physical, emotional or other. It is likely that the trigger to the murder was Mr Underwood's discovery that his wife knew of his affair.

Sadly, it seems that there were no situations identified where, even in retrospect, it would have been possible to recognise any risk of harm to Mrs Underwood, so there were no opportunities for anyone to intervene to protect her.

5. Analysis

5.1 General analysis

It may never be known exactly how or when Belinda Underwood was killed. Her husband Gerald Underwood has been convicted of her murder.

From all the information that has been gathered as part of this review, it does not seem likely that she had been the victim of ongoing physical abuse from her husband that could have suggested a risk of her being murdered. It may be that her murder was a one off event committed at a point of high emotion by her husband, or it could have been a pre-meditated instrumental killing. No events that could have been seen as warning signs had been recorded by any professionals, family or friends.

5.2 Review of Terms of Reference

I found that no information was known by any agencies which could or should have been shared with others in order to identify and manage any potential risks towards Belinda Underwood.
I found that no family members or friends were aware of any abusive behaviour from her husband, or of any behaviour that with hindsight could have indicated abuse of any kind.

I considered whether there were any real or perceived barriers to Belinda Underwood or friends or associates reporting concerns about domestic abuse and whether they knew what to do if they were worried about domestic abuse. I found no indication that there was any type of abuse that could have led to a referral into any local service. The consensus of the panel was that there could be a barrier to recognition of abuse in terms of a lack of understanding across a range of people and agencies that domestic abuse could be experienced by a person like Mrs Underwood. It is not uncommon for people to have a stereotypical image of a victim of domestic abuse, which can mask the fact that domestic abuse can occur across the whole range of women in the community, irrespective of age, class, ethnicity, and other background factors. It does seem that the marriage had not been a happy one in the period before the murder. It may have been that Mrs Underwood was experiencing abuse during this period though there is no evidence to indicate this. It may have been, however, that even if she was experiencing issues that she would not have recognised as abuse, others may have done had they known. This is not uncommon for victims of domestic abuse and clearly presents a barrier to reporting concerns if they are not even recognised by the victim.

I considered whether there were any opportunities for professionals to make “routine enquiries” about any experience of Domestic Abuse by Belinda Underwood. In some local services, including midwifery and adult mental health, enquiries are made routinely about women’s possible experience of domestic abuse. This is only done when it is safe to do so, and not when a partner is present. In A&E enquiries are made when the circumstances of the case suggest potential domestic abuse. There is currently no guidance to GPs or practice nurses about making such enquiries on a routine basis. Mrs Underwood had attended her GP surgery for routine tests and other appointments. This could indicate for the future an opportunity for the nurse or doctor conducting such appointments to ask a routine question about domestic abuse. As women often attend GP practice appointments without their partner, this could be an environment where the question could be asked sensitively and confidentially, which might encourage disclosure.

The review considered whether there was any learning about opportunities to promote a wider understanding of domestic abuse and relevant services available in rural areas. As there was no indication that she had experienced previous abuse in her relationship, it is unlikely that any actions would have made a difference for Belinda Underwood. However, when thinking about possible diversity issues in the case three factors were recognised: Mrs Underwood was a woman over retirement age, she was educated, and lived in a rural area. It was thought that all of these factors could reduce the likelihood that professionals or friends would recognise her as a potential victim of domestic abuse. While most professionals understand that domestic abuse occurs across the full spectrum of age, class, education of

victims, it may be that the prevalent public view does not recognise this, with the possible impact of potential victims not being recognised as such.

While the main purpose of this report is not to decide whether or not the murder of Mrs Underwood could have been prevented, it has quite naturally been the question at the forefront of most people's minds as the review process has progressed. From all the information that has been gathered it seems quite unlikely that any external person could have done anything to change the outcome.

5.3 Recommendations

Recommendation	Lead Agency	Timescale	Evidence of Outcomes
Encourage as best practice that Primary Care staff conducting routine appointments ask women routinely whether they have experienced domestic abuse	Clinical Commissioning Group	By 31.03.2014	Evidence of staff training and briefings delivered Increase in referrals from Primary Care Staff
Agree and deliver an awareness raising campaign to rural areas of the county to highlight that any person can become a victim of domestic abuse in a range of different circumstances.	Community Safety Partnership	By 31.03.2014	Evidence of how awareness raising was completed Increase in referrals from rural areas

5.4 Additional Information

Independently of this review, Herefordshire Council through HPEG and the Domestic Violence and Abuse Steering Group have recently conducted a DVA needs assessment and have produced an action plan which will be monitored through the Community Safety Partnership.