Executive Summary

South Cambs CSP

A Domestic Homicide Review (DHR) concerning the death of Fiona

(October 2023)

Author – Jackie Dadd

Date completed – June 2025

The Domestic Homicide Review Panel and the members of the South Cambs Community Safety Partnership would like to offer their sincere condolences to the family of Fiona, who have lost their loved one in tragic circumstances.

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1. The review process

1.1 This review examines agencies responses, provisions and support provided or available in the Cambridgeshire area to Fiona, a 46-year-old female, prior to the point of her death, having been murdered in her own home by her husband, Timothy in October 2023. The cause of death was found to be compressions of the neck (strangulation). Following an investigation, the Police charged Timothy with murder and following a trial at Cambridge Crown Court, he was found guilty and later sentenced to life imprisonment to serve a minimum of 24 years.

1.2 Cambridgeshire Police made a referral to South Cambs Community Safety Partnership (CSP) in November 2023 for consideration for a Domestic Homicide Review (DHR) and following a meeting held the same day with representatives from local Authorities, a decision was made to undertake a Domestic Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.3 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following: (All ages are recorded at the time of Fiona's death).

Fiona – The deceased. A white British female aged 46 years old.

Timothy – Husband of Fiona. A white British male aged 46 years old. Convicted of the murder of Fiona.
Vicky – Eldest daughter of Fiona and Timothy.
Hannah – Youngest daughter of Fiona and Timothy.

1.4 The Author contacted both daughters, sending them a letter via email due to that being the only form of contact details available informing them of the review, a brief synopsis of the purpose and asking if they would be willing to speak to the Author in more depth and be part of the review process.

1.5 They respectfully replied, declining to partake and requesting no further contact was made with them. They outlined that their father had been wrongly convicted and knew that their mother was not in a domestic abuse setting. They feel a huge injustice has been done. The Author has respected their wishes.

1.6 The Author made contact with Timothy via letter to His Majesty's Prison (HMP) who responded to state that he was willing to speak with the Author. An interview was held with him in which he denied any domestic abuse or murdering Fiona.

2. Review panel members

2.1 The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of IMRs, Summary reports and chronologies. All panel members were independent.

2.2 The panel comprised of the following:

Name	Area of responsibility	Organisation
Vickie Crompton	Domestic Abuse and Sexual Violence partnership manager	Cambridgeshire County Council
Jenny Thompson	Designated Nurse Safeguarding Adults	Cambridgeshire and Peterborough Integrated Care system
Alicia Yorke	Detective Inspector – Domestic Abuse Tactical Lead	Cambridgeshire Police
Richard Stott	Detective Inspector - Senior Investigating Officer	Cambridgeshire Police
Julia Cullum	Domestic Abuse and Sexual Violence partnership manager - IDVA	Cambridgeshire County Council
Kathryn Hawkes	Communities Manager	South Cambridgeshire District Council and representing the South Cambs CSP
Angie Stewart	Chief Executive Officer	Cambridge Women's Aid
Liz Clarke	Service Director – Quality Assurance and Practice Improvement	Children, Education & Families – Cambridgeshire County Council

2.3 Thanks go to all who have assisted and contributed to this review with their valued time and cooperation.

3. Contributors to the review

3.1 The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of scoping their records and if necessary, providing reports and chronologies.

Agency	Contribution
Cambridgeshire Police	Summary report, Panel member
NHS Cambs and Peterborough Primary Care Integrated Care Board (ICB)	Panel member, Summary report

Peterborough and Cambridgeshire Domestic Abuse and Sexual Violence Partnership	Panel member, Oversight,
South Cambs District Council/CSP	Panel member, Oversight
Cambridgeshire Children Services	Panel member, scoping
Cambridge Women's Aid	Summary report, Panel member
Department of Work and Pensions (DWP)	Scoping

4. Author of the Overview report and Chair

4.1 The chair of the review panel and Author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues, having been the Force Lead for domestic abuse, stalking and harassment and serious sexual offences and has been involved in the DHR process since its inception in 2011.

4.2 She has completed several training courses including the Home Office online training, the Continuous Professional Development accredited AAFDA (Advocacy After Fatal Domestic Abuse) DHR Chair training, the domestic Abuse and suicide accredited course, and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has recently completed the new Home Office DHR Chair training to obtain the qualification of a level three certificate.

4.3 Mrs Dadd has completed and published several DHRs.

5. Terms of Reference

The Terms of Reference were discussed and agreed upon during the first panel meeting and was a working document throughout the review.

It was agreed that the main areas of focus and discussion would be based on the following:

a) To establish if Domestic Abuse (DA) in any form had been the causation or contributory factor in the death of Fiona.
b) Are there appropriate safeguarding measures in relation to economic abuse and in particular companies dealing with life insurance.
c) Examine Cambridgeshire's response to Domestic Abuse and any barriers there may be for affluent victims to disclose.

The full Terms of Reference are below:

- The data parameters under consideration for the review were from 2021 up until Fiona's death to incorporate the financial transactions over the past few years.
- This is to be reviewed as a Homicide based on the investigation by appropriate Authorities and the findings of the Crown Court.
- Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process.
- Establish whether agencies have appropriate policies and procedures to identify and respond to domestic abuse. Recommend any changes following the review process.
- Establish whether unconscious bias could be present with professionals decision making and considerations when dealing with persons perceived to be affluent/privileged.
- Establish any barriers that could be faced by a victim suffering from domestic abuse who are affluent and living a wealthy lifestyle.
- Identify any controlling and coercive behaviour by the perpetrator towards victim, family and friends and the effect this may have on them.
- Do communications and publications within Cambridgeshire provide sufficient accessibility to information for the public in relation to domestic abuse.
- Explore safeguarding measures that could assist with preventing economic abuse and whether they would have been accessible to Fiona.
- What processes are in place with life insurance companies for consideration to safeguarding and correspondence with the named subject.
- Were procedures sensitive to the protected characteristics relevant in this case?
- Identify and highlight good practice for wider sharing

6. Summary chronology

6.1 Fiona and Timothy had been married around twenty years and had known each other since they were 17 years old, moving in together a year later and then marrying at 19 years old. They went on to have their two children at 26-27 years old. They lived in a home valued at £1.5m and had a portfolio of a number of other properties.

6.2 In 2007, two separate companies were incorporated in which both Fiona and Timothy were Company Directors. The companies provided financial and mortgage advice and services. One of these companies was dissolved in 2015 and had changed its name on four occasions. Five separate properties were purchased in this time including their home, plus the commercial offices with an accumulative value of around four million pounds, all in the Cambridgeshire area. Companies House shows that the Fiona resigned from being a director of the existing company in 2021.

6.3 Fiona and Timothy had both registered with the same GP Surgery in 2010 and had remained there as patients throughout. Fiona's records show no issues of concern in relation to safeguarding from either her or a third party. The only medical relevance on file was that in 2012, a note was placed regarding a fear of flying following a bad experience and subsequently, received diazepam descriptions ahead of flying.

6.4 At the end of October 2022, Financial debts started to grow against the company from HMRC, a financial company and an insurance company amongst other smaller companies. Timothy made steps to inform them to only contact himself due to Fiona answering a call on one occasion, intimating that she was not aware of the debts that were being accrued.

6.5 Timothy used a number of 'stalling' methods over a number of months including stating that he had cancer, he was going through a divorce and he was unable to sell properties that would fund his debts in order to avoid paying his debts or bot attending meetings, all of which were found to be untrue during the police investigation.

6.6 The business bank account showed a balance of £34.95 that month in which it then had two transfers totalling £150,000 with the reference 'Mam and Dad'. Timothy's laptop showed that over four days at the end of the month, a number of gambling sites were accessed. The business bank account shows gambling transactions over that period amounting to over £2500. Timothy stated that this was an investment by his parents and that they would receive dividends from this.

6.7 By October 2023, debts had cumulatively risen to circa £350k. In the days leading up to Fiona's death and on the day, Timothy's search history on his devices showed that he had made several separate searches relating to diazepam overdose covering the effects, how much to take and if it is possible. Ten minutes after his mobile phone connected with his Ford Focus, he made ten separate searches relating to how to disable a passenger airbag in a Ford Focus 2020 which included three you Tube videos. This was just prior to knowing Fiona would be a passenger in his vehicle. He also contacted the insurance company and re-instated both his and Fiona's life insurance policies, paying the arrears and on request, established both end dates of his and Fiona's policies.

6.8 The day before Fionas death, around lunch time, Fiona's search history on her mobile phone showed searched items of 'narcissist' and 'narci'. Shortly after this, a text conversation takes place with a friend inviting Fiona and Timothy to go on a dog walk with them. At 15.03hrs, Fiona agrees and says they can be ready in 10 minutes. After two chase-up texts, Fiona replies at 15.30hrs stating that they cannot go as the dog has hurt his leg. Two minutes later, for a period of two minutes, Fiona search history shows searches for narcissist, narci, narcissist meaning in a relationship and then entered the website of Silent Rights – Empowering women to heal and rebuild after domestic abuse[1]. It is not known why this website was chosen.

[1] https://silentrights.co.za/?https://silentrights_co_za/&gclid=EAIaIQobChMIy-Pd6fqYggMVUuztCh0m7gWgEAAYASAAEgJqNfD_BwE

6.9 Having gone to bed earlier than Timothy, just before midnight, Timothy's exercise app shows his heart rate exceeding that of the exercise workout he had completed earlier and was exceptionally high for over three minutes. Within the next two hours, he then disarms the house alarm, plugs his mobile in on three occasions and unlocks it on seven occasions. This behaviour was entered into prosecution evidence as an indication of the time the murder occurred.

6.10 At 01.51hrs, that same night, Timothy then phones 999 from his mobile phone and speaks to the ambulance service for over eight minutes in which he purports to be completing CPR. Ambulance staff informed Police officers at the scene that they did not think that CPR had been conducted and pointed out bruising in which the Sergeant at the scene made the decision that Timothy had provided a plausible explanation as the deceased's injuries may have been associated with medical interventions and did not appear deliberate or defensive in their nature or appearance. There were no signs of a disturbance or third-party involvement.

6.11 A post-mortem was completed three days later on the same day that Timothy was arrested for drink driving following a road traffic accident. A forensic postmortem took place some ten days later. The forensic post-mortem found the cause of death to be compression of the neck (strangulation) and Timothy was arrested on suspicion of murder the same day.

6.12 Timothy was charged with the murder of Fiona and following a trial at Cambridge Crown Court where he vehemently denied causing her harm, a jury found him guilty of murder with a unanimous verdict and he was sentenced to life imprisonment with a minimum term of 24 years.

7. Key issues arising from the review

7.1 The importance of effective listening to professionals in their field

The Police Sergeant who attended the scene of Fiona's death was not a qualified detective and the issues surrounding expertise in attendance of Sudden and unexplained death's is outlined below at 9.2. The lack of identification of suspicious circumstances at the scene led to a standard post-mortem which was stopped due to early findings and a significant delay in the forensic post-mortem and arrest of Timothy, causing forensic potential issues at the scene.

There were a number of causes at the scene of Fiona's death to raise concern to the police that should have been identified as such.

- The nature and cause of injuries and accessibility of medication
- The veracity of Timothy's account could not be checked or corroborated independently, especially as the deceased was cold to touch, indicative of death having occurred some hours previously, albeit rigor mortis had not yet set in

- Paramedics expressed their concerns regarding CPR not having been administered prior to their arrival

8. Conclusions

4.1 It is known that the companies owned by Timothy and Fiona and also Timothy's personal financial circumstances had large debts to several different organisations which was in stark contrast to the lifestyle and affluent image that was portrayed with an expensive house and portfolios of properties and expensive trips abroad. It is known that Fiona had her own savings but it is not known if Timothy was aware of this prior to her death. There is a text where he is asking her if business debts on the credit card could be paid by her savings, but the police found no direct evidence of economic abuse against Fiona other than that of her murder. The prosecution case suggested the motive was to obtain her money and life insurance to pay the debts. There is information found within this review that highlights subtle actions by Timothy to control the finances which the panel believe to be economic abuse. There is a lack of research on the understanding of how domestic abuse affects the affluent, which prevents informed support in this area. (Recommendation refers)

4.2 Research by Professor Jane Monckton-Smith demonstrates that intimate partner homicides rarely occur as a sudden loss of control but instead, follow an identifiable pattern, often driven by escalating coercive control and perceived loss of power. Her eight-stage homicide timeline shows that financial instability, such as mounting debt, loss of income or financial exposure, can act as a trigger point for some perpetrators. The research provides an evidence-based explanation for how significant debts or financial collapse can contribute to the escalation of risk including the risk of homicide, when control is threatened.[2]

4.3 Timothy made attempts to prevent their insurance company from speaking to Fiona. Fiona was unaware of Timothy's dealings in relation to her life insurance. The panel have reviewed this and it is their understanding that, in line with GDPR, one spouse can be nominated to speak about the life insurance of the other. It is not known whether Fiona's permission had been sought for this in relation to the specific issue of updating the policy and paying off any arrears. This creates a loophole for which the Surviving Economic Abuse charity are campaigning for change. The panel also reflected as part of a wider conversation about domestic and financial abuse, that the barriers to leaving an abusive relationship might have been increased for Fiona as she was

a) in a marriage and

b) run a company with Timothy.

[2] In control - Dangerous relationships and how they end in murder – Jane Monckton-Smith (book)

Taken together, these factors made their lives intrinsically linked and more difficult to separate.

4.4 There were a number of causes at the scene of Fiona's death to raise concern to the police that should have been identified as such.

- The nature and cause of injuries and accessibility of medication
- The veracity of Timothy's account could not be checked or corroborated independently, especially as the deceased was cold to touch, indicative of death having occurred some hours previously, albeit rigor mortis had not yet set in
- Paramedics expressed their concerns regarding CPR not having been administered prior to their arrival

4.5 No domestic abuse history should not be assumed to suggest that domestic abuse does not exist. These are areas that may have been identified if a Detective Inspector who is a trained investigator and experienced had attended. Cambridgeshire Police and the MCU held a de-brief and identified these issues and made an internal action plan from their findings which is good practice. However, the panel felt that due to the delay in the implementation of the process recommended in 2021, selected recommendations would be mirrored in this report as they were also the findings of the panel and this would give further oversight on their progress.

4.6 As it may take some time and a lot of courage for a victim to finally take the step to reach out for support, the panel felt that the wording of Cambridge Women's Aid's (CWA) automated email response may make the victim feel rejected and not have the courage to reach out to another service provider that is suggested. This observation was acknowledged by CWA and they will scope as to how this can be re-worded. (Recommendation refers)

4.7 Although the GP Surgery state that part of their protocol is to ask patients whether they feel safe at home, there is no record of Fiona ever being asked this or a similar question so it cannot be ascertained whether Fiona would have been given the opportunity to disclose any abuse or not. If the questions are asked, it is essential that accurate recording of any disclosure or not is made to assist with risk assessing the patient.

4.8 Both the police, from their investigation and the panel, from the review of the circumstances, found that Fiona was an intelligent woman and would know where to look for support and information, but it cannot be known at what stage she may have realised what was happening to her. Her searches in relation to narcissism and on the Silent Rights website indicate that she was aware just prior to her death and may have thought about leaving the relationship. One of her last searches was in relation to a property for sale in Majorca.

4.9 During the trial at Crown Court, Timothy maintained his lies until he could do so no longer during cross examination. He had portrayed himself as very accomplished and convincing in what he had to say which are traits that would assist him with controlling not only Fiona during their marriage and not telling her the truth, but also his daughters by convincing them of his narrative as he had spent their lifetime doing this.

4.10 It is accepted by the panel that unconscious bias by professionals can be present when speaking with someone who is articulate and appears affluent/middle to upper class. Furthermore, it was accepted that events are sometimes not looked at holistically, because the explanation of events as presented by the person is believable, more so than perhaps if someone less articulate were to say the same thing.

4.11 Fiona had never reported or disclosed being subjected to domestic abuse to the police, any other Authorities, her family or friends but this does not mean that she was not subject to abuse. The research found during this review outlines the barriers that a person in Fiona's position may face and that of any person being abused.

4.12 Due to the information found within this review, sexual abuse could not be discarded due to the findings at the postmortem. The prosecution case that Timothy killed Fiona in order to gain money to repay his debts could be construed as economic abuse although specific evidence of economic abuse prior to her death during the homicide investigation was not identified. Coercive and controlling behaviour can be identified through Fiona's internet searches about narcissism in a relationship. Abusers use different forms of control at different times. It should be acknowledged that economic abuse can occur intermittently or alongside other forms of coercive control. Fiona clearly thought that her husband showed traits of a narcissist and the timing of the 'about turn' in her decision to walk the dog with friends in such a short space of time between her searches on the internet implies something had happened to prompt a change for Fiona. Physical abuse was shown during Fiona's death due to her strangulation and suffocation by Timothy which is an extreme act of violence. [3]

4.13 Within the last two days of her life, Fiona searched the website of Silent Rights – Empowering women to heal and rebuild after domestic abuse which the panel believes is evidence that she knew that she was being abused and was thinking of rebuilding her life away from him.

9. Lessons to be learnt

9.1 Unconscious bias for the affluent

Fiona and Timothy's house was in an affluent area and was worth one and a half million pounds. They owned mortgage companies and several other properties and although in debt, to the 'outside world' it appeared that they were privileged and wealthy. Timothy was articulate and not averse to telling lies in order to convince others of his narrative.

The panel considered whether this perception has any influence on Authorities when considering the full circumstances and in their decision making. Panel members agreed that

[3] The Violent Reality of Strangulation - The SAFE Alliance

professionals ‘across the board’, not just the police, succumb to this and professionals should be ‘thinking the unthinkable’ and not taking things at face value.

Training in this area should also be focussed and understanding of the difficulties faced by an affluent person to leave an abusive relationship and the barriers they face.

9.2 The timeliness of change

A previous DHR held in Cambridgeshire in 2021 (Rosita) identified a lack of experience, wider thinking and rank when the Police attend sudden deaths and a recommendation was made for the collaborated Police Constabularies of Bedfordshire, Cambridgeshire and Hertfordshire to revise their Homicide, sudden and unexplained death procedure (BCH09/009) policy to include the fact that an officer of the rank of Detective Inspector should attend the scene of any death whereby there may be suspicious circumstances or conflicting information received.

Although there were concerns raised at the scene on Police attendance whereby the paramedics did not think that Timothy had performed CPR and expressed concerns over Timothy’s account to them, the Temporary Police Sergeant at the scene made the decision that there were no suspicious circumstances and that Timothy’s explanation in relation to bruising and blood found was plausible. No professional curiosity by the police was evident at that time.

A de-brief was held between the collaborated Major Crime Unit and Cambridgeshire Police which was good practice in which one of their recommendations was to consider alteration to the current Force Policy. In discussion at the panel meeting, it was outlined that the original recommendation had been discussed and had taken a long period of time to ratify due to having to go through the agreement of three Forces but is due to be signed off during April 2025.

Had this been ratified sooner, this would have provided guidance to the Sergeant at the scene and experienced oversight of the information gathered at the scene with a Detective Inspector’s attendance.

10. Recommendations

National

1. **South Cambs CSP to write to the DA commissioner and request they identify a relevant body to complete research for publication into domestic abuse within affluent relationships.**
   This will assist with professionals' knowledge and understanding of domestic abuse within affluent relationships and would also ensure the correct support and safeguarding measures are utilised.

Local

2. **The Joint Protective Services (JPS) of Bedfordshire, Hertfordshire and Cambridgeshire Police Constabulary's are to implement a streamlined and expedited process for the change of policies and procedures that affect all three Forces.**

   This will ensure that when a need for change is identified, it can be agreed upon and implemented at the earliest point available to ensure best practice is not delayed and opportunities missed.

3. **Cambridgeshire Constabulary to receive further/refresher training for the workforce regarding attendance and management of unexplained deaths including the initial assessment of injuries (bruising unlikely to occur post death) to assist with recent or non-recent initial responses to sudden deaths where there is ambiguity relating to the death being suspicious or unexplained.**

   This will provide training on the investigative building blocks and the basics of the principles of 'assume nothing, believe no one, check everything' to ensure all information is gathered and assessed prior to decision making. This will also assist with the understanding of what health professionals such as paramedics are informing them at the scene. It is not for them to assess medically as a standalone.

4. **GP Surgery to communicate to all employed practitioners to make asking and recording of whether a patient feels safe at home or similar safeguarding questions to be part of everyday practice.**

   This will provide the opportunity for disclosure for the patient and sufficient recording of the conversation to be able to risk assess and refer back to at a later date if further disclosures are made.

5. **DASV to review funding streams to scope the feasibility of funding a triage worker for Cambridge Women's Aid to enable them to speak to women who contact them and refer on to alternative similar support services such as DASS.**

   This may enable CWA to respond to those who contact them but they do not have capacity for and assist with a referral to another agency for support as they may not feel able to do this on their own.

6. **Domestic Abuse and Sexual Violence partners (DASV) to utilise this review as a case study for learning across organisations within Cambridgeshire in the unique areas highlighted in this review surrounding affluence, narcissism within domestic abuse and unconscious bias.**

   This will ensure that organisations and agencies within Cambridgeshire have an understanding of the barriers and unique issues that affluent people may face when being abused. Also, that they ensure that they do not just assess what they can see in front of them but hold deeper considerations to holistically assess people and circumstances.