Domestic Homicide Review

Dorothy/April 2018

Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review completed: 16th October 2019

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CONTENTS

1. Introduction 1
2. Methodology 3
3. The Review Process 5
3.1 Contributors to the review 5
3.2 Review Meetings 6
3.3 Parallel reviews 6
3.4 Equality and Diversity 6
4. The Death of Dorothy Walton 8
5. Background Information 8
6. Chronology 8
7. Analysis 11
8. Conclusions 13
9. Lessons to be Learnt 14
10. Recommendations 14

Terms of Reference — Appendix A

Glossary — Appendix B

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1. Introduction

1.1 This report of a Domestic Homicide Review examines agency responses and support given to Dorothy Walton, a 'Kent and Medway' resident prior to the point of her death in April 2018. It also covers agency involvement with her husband Derek Walton, who caused her death.

1.2 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, 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.

1.3 Dorothy was diagnosed with dementia in 2008. She remained at home, with occasional periods of respite care, until October 2017 when she became a full-time resident of Care Home A. Her husband of 66 years, Derek, visited her daily and spent time with her assisting with some of her care. Sometime during April 2018, Derek asked the Manager of the home whether he might take Dorothy home for a day to enjoy the improving weather in the couple's garden. There was no reason from what was known to do anything but support this request and on one day in April 2018, at about 14:00, Derek took Dorothy home in a taxi. At around 18:00 the couple's son, John Walton, arrived at the house and found both Derek and Dorothy deceased.

1.4 An inquest in September 2018 confirmed that Dorothy had died by strangulation and Derek had died by hanging with the outcome recorded by the Coroner as unlawful killing and suicide respectively. The Coroner's report was shared privately with the Independent Chair.

1.5 The family have, understandably, been deeply upset by this tragedy, and our sympathies are with them.

1.6 All names within the report have been anonymised and are highlighted below for the purposes of the report. The fictitious names were chosen to reflect generation and ethnicity. Normally the family would have been consulted with regard to the choice of pseudonym but, in the circumstances, this was not possible.

Deceased: Dorothy Walton – White British female, mid 80s.
Husband: Derek Walton – White British male, late 80s.

Name	Relationship with Dorothy Walton
Derek Walton	Husband
Carol Davis	Sister
John Walton	Son
Anne Walton	Daughter-in-law

Purpose:

The key purpose of a Domestic Homicide Review (DHR) is to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) Identify clearly what lessons are both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result;

c) Apply those lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity and

e) Highlight good practice.

Scope

The review will consider agencies' contact/involvement with Derek and Dorothy from 1st November 2016 to the date of the deaths in April 2018. The panel felt it appropriate to look at current, or recent, practice and the opening date was chosen as a time when Dorothy's condition began to deteriorate.

Terms of Reference

The terms of reference for this DHR are set out in Appendix A to this report.

Timescales

This review began on 10th May 2018 and the Independent Chair was appointed on 18th June 2018. The Terms of Reference were agreed on 9th July 2018.

It had been hoped that, with time, the family would agree to be involved in the review but for fully understandable reasons set out below, this has not proved to be the case. Completion of the report was subsequently delayed to allow the opportunity for family engagement and was resumed in May 2019.

The final Overview Report was completed in October 2019 and subsequently underwent a quality assurance process within the Kent Community Safety Partnership in preparation for submission to the Home Office.

2. Methodology

2.1 Notification of the death of Dorothy was made to the Kent Community Safety Partnership on 25th April 2018. In accordance with section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 10th May 2018 and confirmed that the criteria for a Domestic Homicide Review had been met.

2.2. For this review, each agency that had substantive contact with Derek and Dorothy between November 2016 and April 2018 were asked to provide an Independent Management Report (IMR) setting out their contact. This is standard practice for Domestic Homicide Reviews.

2.3 For objectivity and independence, an IMR was completed by a member of staff from the agency concerned who was independent of the case and the direct line management structure.

2.4 **Involvement of family, friends, work colleagues, neighbours and the wider community.**

2.4.1 All those involved in this review express their sincere condolences to the family. The deaths of Dorothy and Derek were a tragedy, the unexpected circumstances making this all the more difficult for the family who are, understandably, traumatised.

2.4.2 Letters explaining the DHR process together with the Home Office leaflet and an explanation of GDPR (General Data Protection Regulation) were hand delivered to John and Anne Walton (son and daughter-in-law) and to Carol Davis (sister of Dorothy).

2.4.3 On 27th July 2018, the Independent Chair visited the home of John Walton following an introduction by the Police Family Liaison Officer who was also present. John indicated that he had things to say and

that he would like to contribute to the review, however he was too upset to do so at that meeting. The meeting was curtailed on the basis that the Independent Chair would visit on another occasion when both John and Anne were present so that they were able to support one another. The intention at that time was for further explanation of the process, including any further referrals or discussion of advocacy services to take place later. For reasons set out below no further direct engagement with the family took place.

2.4.4 The Independent Chair wrote to John and Anne on 8th August 2018 seeking to arrange a time to visit. He was subsequently rung by Anne who felt that events were too "raw" for them to participate at that time, their focus being on getting through the inquest planned for the following month. It was agreed that they would be contacted once the report was in draft form to see whether they then wished to contribute. The Independent Chair left his contact details in case John and Anne wished to contact him in any form once the inquest was over.

2.4.5 A point made by Anne was that the family did not accept the need for a Domestic Homicide Review because there was no evidence to suggest that the couple were in anything other than a loving relationship. Bearing this in mind, this review has adopted a proportionate response and focused on areas where agencies involved in their care could have been improved.

2.4.6 Further letters were sent to John and Anne and to Carol Davis on 28th January 2019. The letter to Carol was successfully delivered but the letters to John and Anne were not collected from the delivery office and were subsequently returned to the Kent Community Safety Team.

2.4.7 The Police Family Liaison Officer had kept in touch with the family throughout and offered to facilitate a meeting. He rang the Independent Chair on 10th April 2019 to say that he had spoken to the family and whilst they were not prepared to meet, they were in agreement to talking on the phone and would ring in due course.

2.4.8 In spite of two further messages left by the Family Liaison Officer, John and Anne did not ring and in consultation with the Family Liaison Officer, the Independent Chair decided on 2nd May 2019 that it would be best for no further contact to be attempted.

2.4.9 A final letter was sent to John and Anne in January 2020 in accordance with the Home Office guidance to inform them that the report was ready to be sent to the Home Office for quality assurance; and to offer them a final chance to view the report and its conclusions

and the opportunity to contribute toward the review. Again, the letter was not collected from the delivery office.

2.4.10 It was because of John's indication that he had "things to say" back in July 2018 that time was taken to attempt to include the family. Comments from the family would have been helpful in preparing this report but it is entirely understandable that they did not wish to be involved. In their words to the Family Liaison Officer, they "wanted to get on with their lives". This is fully understood and respected.

3. The Review Process

3.1 Contributors to the review

3.1.1 The review panel consisted of the Independent Chair and senior representatives of those organisations that had relevant contact with Dorothy and Derek. It also included an independent representative from SATEDA (Support and Action To End Domestic Abuse) and a senior member of the Kent County Council Community Safety Team. Whilst the panel did not include an independent age or dementia specialist, individual panel members had direct professional experience of working with dementia and/or managing those who did. The Independent Chair was confident that the necessary skills, knowledge and experience was available to the panel.

3.1.2 The members of the panel were:

Alan Critchley	Independent Chair
D/S Susie Harper	Kent Police (early stages)
D/S Lee Whitehead	Kent Police (later stages)
Catherine Collins	Adult Strategic Safeguarding Manager, Kent County Council Adult Social Care and Health
Richard Hill	Strategic Safeguarding Adults Lead, Town A - Local Authority (early stages)
Bill Brittain	Head of Specialist Services (Adults) Town A Local Authority (later stages)
Michele Sault	Designated Nurse for Safeguarding Children and Families, Town A - Clinical Commissioning Group
Bridget Fordham	Head of Safeguarding, Town A - NHS Foundation Trust
Theresa Ward	Care Home Manager, Care Home A
Honey-Leigh Topley	Community Safety Officer, Kent County Council Community Safety
Liza Thompson	CEO, SATEDA

3.1.3 Those who provided Individual Management Reports (IMRs) and short reports:

- Care Home A
- Town A - Local Authority
- Town A - NHS Foundation Trust
- Kent Police
- Town A - Clinical Commissioning Group (Primary Care)
- Respite Care Home - Brief Report only

3.1.4 The Independent Chair of the Panel, who is also the Overview Report writer, is a safeguarding consultant. He is a qualified and registered Social Worker. He has held a number of safeguarding roles and was, from 2015 to 2018, the Independent Chair of the Walsall Safeguarding Children and Adults Board. Apart from this and another DHR he has no connections with any agencies in Kent and Medway (including the Kent Community Safety Partnership) and does not live in the area. He is therefore independent of all agencies and people involved in this review.

3.2 Review Meetings

3.2.1 The review panel met initially on 9th July 2018 to discuss the Terms of Reference (see Appendix A), which were then agreed by correspondence. The review panel then met on 7th November 2018 to consider the IMRs and again on 10th December 2018 to consider the draft Overview Report. All subsequent amendments to the Overview Report were agreed by email correspondence up until October 2019.

3.3 Parallel reviews

3.3.1 An Inquest was held in September 2018 into the deaths of Dorothy and Derek with the outcome of unlawful killing and suicide respectively. The Coroner commented that this was a “tragic, tragic case” and said of John’s discovery of his parents’ bodies that this was a “truly dreadful experience for him”. The Coroner’s report was shared with the Independent Chair of the review panel who authored the review.

3.4 Equality and Diversity

3.4.1 Age is a factor in this review, as is marriage. Due to the nature of Dementia, age is a factor as these circumstances are unlikely to arise in younger people. For Dorothy and Derek, that they had been married for nearly sixty-six years was the significant factor in this case. They had been described by family as being “totally devoted to each other”. Latterly, Dorothy was totally dependent upon Derek for

all her care needs. It was the separation, and its circumstances, after so many years that appeared to be the catalyst for the tragedy.

3.4.2 The review group considered whether gender was an issue as it is widely acknowledged that violent assault by men is more common than by women. There is, however, limited relevant research into homicides in respect of the elderly where dementia is a factor meaning that no clear causal link with gender can be made in this instance. It is however the case that up to 38% of homicides of women are committed by male intimate partners *(ref WHO 2014 Global Status Report on violence prevention).* This figure is six times higher for women than it is for men meaning that it is far more likely that a woman will be murdered in these circumstances than a man.

3.4.3 Further, the Home Office analysis of Domestic Homicides *(Ref Office of National Statistics 2016)* found that 97% of women domestic homicide victims were killed by men whilst only a third of male domestic homicide victims were killed by a woman.

3.4.4 The summary of the research available to this review is that a woman is far more likely to be a victim of homicide than a man, as happened in this case.

3.4.5 Benbow, Bhattacharyya and Kingston *(ref Older Adults and Violence: An analysis of Domestic Homicide Reviews in England involving adults over the age of 60. Cambridge University Press 2018)* found that age was not conclusively relevant but "that stereotypes and assumptions about age influence the health and care assessments made and interventions offered". Further comment on this is made in the conclusion.

3.5 Dissemination

3.5.1 The following will be recipients of the Overview Report:

- The Family of the deceased subject to their wishes
- All panel members who will be responsible for disseminating to all staff within their organisation
- The Head of the Kent Community Safety Partnership
- The Kent Police and Crime Commissioner
- The report will be available on the Kent.gov.uk and Medway.gov.uk websites.

4. The Death of Dorothy Walton

4.1 Dorothy and Derek Walton lived in Town A. On the day that Dorothy and Derek died, Derek had gone to Care Home A where Dorothy was now a resident, as he did on most days, and on this occasion had lunch with Dorothy, which whilst not usual it was not remarkable and did not stand out at the time. Earlier in the week Derek had mentioned to the Care Home Manager the possibility for them to both spend time in the garden at their home as the weather was improving after a long winter. So, a taxi was called to take himself and Dorothy home. They left the Care Home at approximately 14:00 and would have arrived home at approximately 14:20. John visited the house at approximately 18:00 and found both his parents to be deceased.

5. Background Information

5.1 Prior to Dorothy's move to Care Home A the couple lived alone in their house in Town A. From October 2017 Derek lived alone. They had one son, John, whose wife Anne was also involved in caring for the couple as was Dorothy's sister, Carol Davis.

5.2 Dorothy and Derek had been married for 66 years. John and Anne describe them as a "loving couple" and at the Inquest, John paid tribute saying that "they were devoted to each other".

5.3 Without involvement with the family, it has not been possible to obtain further information for this section.

6. Chronology

6.1 In September 2008 Dorothy was seen by her GP following concerns that she was suffering from memory loss, one indicator being that she had forgotten her son's address. Tests followed and in November 2008 Dorothy was referred to the Dementia Access Clinic. By March 2009 the diagnosis of dementia was confirmed, and medication improved the situation to some extent. Throughout this period Derek was noted to be "supportive".

6.2 Adult Social Care received their first referral on 28th August 2015. A Care Act (2014 Section 9) assessment was completed days afterwards and on 7th September 2015 a support package was put in place comprising a half-hour visit seven days a week to help with a shower and dressing.

6.3 On 18th December 2015 a further assessment took place following a request from family and a period of respite at a Respite Care Home was agreed for a week starting from 16th January 2016.

6.4 A further assessment on 4th February 2016 arranged for two days a week attendance at an Age Concern Day Centre with provision for people with dementia; this commenced on 11th February 2016 and continued until Dorothy became a resident at the Care Home A in October 2017.

6.5 On 12th May 2016, it is noted from a letter to the GP from Kent and Medway NHS and Social Care Partnership Trust (KMPT) that Derek was finding it difficult to cope with Dorothy's deteriorating dementia and was considering whether residential care might be the best option. It would have been good practice for the GP to follow this up and discuss it with Derek but there is no record of this.

6.6 On the 29th September 2016 whilst at the Age Concern day centre, Dorothy collapsed with a suspected vaso-vagal[1] episode and an ambulance was called. She was later well enough to be discharged home. This is indicative of a deteriorating physical condition.

6.7 Derek contacted the GP surgery requesting support with Dorothy's increasing confusion on 7th November 2016. There is no evidence that the GP acted on this.

6.8 On 13th December 2016, Anne contacted the Local Authority Town A to say that she felt that her father-in-law required further support. On the 23rd December 2016, an assessment was completed and stays at the Respite Care Home were agreed for one week every two months and Dorothy was booked into respite for a week from 30th January 2017.

6.9 On 2nd February 2017 five further periods of respite care were booked for a week every two months.

6.10 In March 2017, Dorothy was an inpatient at hospital from the 2nd to the 6th for a medical condition unrelated to her dementia. It was recorded that whilst in hospital, Dorothy was confused, agitated and wandering. Her care needs were significant and on two occasions during this stay, Derek made it clear that he was unable to take Dorothy home until her medical needs had been addressed.

6.11 In June 2017 whilst subject to a period of respite care at the Respite Care Home, Dorothy was the subject of an assault by another resident. A safeguarding alert was raised and the police informed, though as both residents suffered from dementia it was considered appropriate to take no action beyond ensuring that their future stays did not coincide. Derek agreed that no intent or harm had been done and he agreed, having Power of Attorney, that no further action would be taken.

[1] **Vasovagal** syncope occurs when you faint because your body overreacts to certain triggers, such as the sight of blood or extreme emotional distress. The **vasovagal** syncope trigger causes your heart rate and blood pressure to drop suddenly.

6.12 Around this time, the Manager of the Respite Care Home spoke to the Social Worker about whether Derek was coping at home as the family felt that he was "struggling". As a result, a further Care Act review took place on 26th July 2017, where the review records show that Derek felt that he was managing with the existing support package and as a result, no changes were made to the care arrangements. There was no suggestion that Derek lacked the capacity to fully understand the review process of his caring role.

6.13 On 31st July 2017, Anne emailed the Social Worker to say that Derek was really struggling and requested a full reassessment of needs with a view to considering whether it was the time for Dorothy to move to 24-hour residential care. It was agreed that the assessment would wait until Dorothy returned from her next period of respite care (10th to 21st August). The assessment took place on 23rd August 2017 with the result that Dorothy's needs would best be met in residential care as her behaviours and needs had increased greatly. This included wandering and urinary incontinence.

6.14 On the same date the Social Worker also completed a mental capacity assessment to determine whether Dorothy had the capacity to understand and agree to permanent residential care. She determined that Dorothy did not have the capacity and completed the Best Interests decision paperwork necessary for the move to residential care. Derek and Carol Davis (Dorothy's sister), were consulted on the decision.

6.15 A residential placement was agreed by the Local Authority Best Interest panel on 5th September 2017. It then took four weeks to identify a home that suited Dorothy's needs and was accessible to Derek. Dorothy moved into Care Home A on 8th October 2017.

6.16 On the same date, the Manager of Care Home A made a Deprivation of Liberty Safeguards (DoLs) referral to the Local Authority. This is routine practice following admission to a care home. Following screening on the 10th October 2017 the case was given a "moderate" priority rating.

6.17 A Care Act assessment should have been scheduled to take place four weeks after admission but, due to an oversight, this was not done.

6.18 There was little agency involvement between Dorothy's placement at Care Home A and her death in April 2018. It is recorded that Derek visited her on most days. Derek's behaviour towards Dorothy was described by the home as "always loving and tender" and that "Dorothy always appeared calm, happy and at ease in her husband's presence".

6.19 A few days before Dorothy died, but the exact date was not recorded, Derek had spoken to the Manager of Care Home A of his wish to take Dorothy home to enjoy the garden and spend some time alone. There was no reason for this to be queried, particularly as Derek had Power of Attorney covering Finances and Health and Welfare and that there were no indicators that he was in any way a risk to Dorothy.

6.20 On the day of this return to their home together both Derek and Dorothy Walton were found deceased.

7. Analysis

7.1 All accounts, from family and those working with Dorothy and Derek are that they were a loving couple. Dorothy had lost capacity due to dementia but the evidence we have seen is that Derek cared deeply for Dorothy. He provided care for her for as long as he was able, he attended most of her appointments and assessments and cooperated fully with those supporting Dorothy.

7.2 In line with the statutory requirements of a Domestic Homicide Review, those compiling IMRs have considered whether domestic abuse was a factor in Dorothy's death. There is no escaping that causing the death of another is, by its nature, abusive but there is no evidence that domestic abuse as it is normally understood was a factor here prior to the homicide itself.

7.3 The Review Panel were satisfied through the content of the IMRs that those working with Dorothy and Derek were experienced and appropriately qualified to recognise domestic abuse had it been present.

7.4 Likewise, through the content of the IMRs the Review Panel were also satisfied that all relevant agencies had appropriate policies in place with regard to domestic abuse.

7.5 Following Dorothy's diagnosis in 2008/9 there was little agency involvement that was not routine until 2016. Dorothy's condition was supported largely by Derek with support from the family.

7.6 When Dorothy's condition began to worsen in 2016 intervention was appropriate, if reactive. What is meant by this is that agencies responded to requests from the family and planned accordingly. This is an observation rather than a criticism; the alternative would be to assume that the condition would worsen and to plan for the longer term. The fact that Dorothy had the same social worker through the period under review is a positive demonstrating continuity and good practice.

7.7 The Review Panel queried whether there was sufficient understanding of Derek's position in supporting Dorothy. A key example is that whilst Dorothy was hospitalised in March 2017, the nursing care provided was set at 1:1 level due to the severity of her dementia. This was days before Derek's birthday and it was known that he would be her sole carer on her discharge. Whilst Derek's age may have been a factor, it is also the case that Dorothy's medical needs were such that anyone, of any age and experience, would have found it difficult to properly support her. A realistic assessment of this may have shown that Derek would be unable to meet Dorothy's needs on discharge and that he required additional support. Indeed, the hospital IMR records that there was a missed opportunity to refer to the hospital Discharge Team on the 6th March 2017 which would have been good practice.

7.8 By all accounts Derek was a loving husband who did all that he could. The family may well have known how he was coping but the panel has seen no evidence to suggest that professionals working with the family did, or that Derek received all the personal support that he could have done. The Hospital IMR records that Derek had suffered from depression and anxiety, though there were no further details and this was not initially corroborated by the CCG IMR. In response to a request for further information from the Independent Chair, the CCG IMR author searched back further in the records which showed that Derek had suffered from "anxiety" since 1977, having been described in 1998 as "a very anxious person". He was still prescribed an anti-depressant in 2017 and so anxiety/depression seems to have been very much a part of his life. In conjunction with Derek's age this may have given further weight for a proactive assessment earlier and additionally the potential for a discharge from Hospital plan for Dorothy in March 2017. Failure to follow up on the diagnosis of depression and anxiety in respect of Derek appears to have been a missed opportunity.

7.9 For Derek, the separation when Dorothy moved to permanent residential care after 66 years of marriage was difficult. We know that he visited her on an, almost, daily basis and it seems that she remained the focus of his life. Whilst it could not have been anticipated that Derek would take both their lives, there may not have been sufficient attention paid to the loss that residential care for Dorothy meant to him. It is possible that the Care Assessment, that should have been completed within 28 days of Dorothy's admission to the Care Home (6.15), might have identified that Derek was struggling with the separation. There was a potential missed opportunity here.

7.10 The Review Panel considered whether the delay in finalising a DoLs assessment had relevance and concluded that it did not. As have many areas, Town A Local Authority has a significant backlog of DoLs applications and have adopted an appropriate triaging process agreed by the Association of Adult Directors of Social Services and this provides for review of individual cases as necessary.

7.11 The panel identified good practice in respect of timetables for assessments/interventions by Adult Social Care with delays being minimised. In addition, a month from agreement for residential care to being provided with an appropriate home is good practice, particularly as a first home was ruled out by Derek due to his difficulty in travelling there and another because they could not meet Dorothy's needs.

7.12 The panel noted that there does not appear to be relevant research into Domestic Homicides within the elderly population where dementia is a factor. The review panel also made enquiries with Dr Hannah Bows from Durham University, given her research areas around violence against older people. However, it appears there is still a gap when it comes to the types of circumstances as seen within this review.

7.13 Following the family decision to not participate in the review, a proportionate review was undertaken and it is acknowledged that the analysis relating to this tragic death will therefore have its limitations. As such, analysis of agency IMRs, and other relevant and disclosable documents provide the core source of evidence for this analysis.

7.14. Reviews such as this will always be enhanced by hearing directly from family and close contacts about the individuals involved. It is acknowledged that the "voices" of Derek and, in particular, Dorothy are missing from this review.

8. Conclusions

8.1 From the outset there was no suggestion from the contributions to the review by agencies that Dorothy and Derek had anything other than a loving relationship. Nothing has emerged from this review to contradict this and I can confirm that prior to the tragic events in April 2018, there is no suggestion of violence or abuse in their relationship. In this instance the sole episode of abuse appears to have been the final one in which Dorothy was, ultimately, unlawfully killed.

8.2 However, as Dorothy's dementia advanced, the strain on Derek increased, albeit he had support from family and agencies. There may have been insufficient attention paid to Derek. It seems that he was content to have been the main carer until October 2017 but the difficulty he was in was probably underestimated, especially around and after the time of Dorothy's discharge from hospital in March 2017, when he was clear that he couldn't support Dorothy's medical needs.

8.3 The loss that one partner feels when separated from another, in this case after 66 years, may well have been underestimated in providing personal support for Derek.

8.4 Although the outcome was an unusual and tragic one, there are many people who find themselves in Derek's situation and this needs to be borne in mind when undertaking assessments.

9. Lessons to be Learnt

9.1 This DHR does not identify any lessons that relate specifically to domestic abuse but does draw out some potential learning in relation to elderly people and separation.

9.2 After living for 66 years with Dorothy, there would inevitably be increased anxiety for Derek once Dorothy moved to full-time residential care. This is to be expected and ongoing support for the carer should be considered in the assessment process. The knowledge that Derek had suffered from depression and anxiety significantly strengthens this observation.

9.3 The IMRs do not give a sense of how Derek was coping on a personal and emotional level, this may be because no one working with Derek knew. There was mention that Derek was not coping on a practical level, but this was insufficient to fully understand the situation that he was in. It may be helpful to make more explicit in assessments how the partner remaining at home will manage and how they can be supported in their change of circumstance.

9.4 There were some occasions where Anne contacted agencies shortly after Derek had done (6.7 and 6.11). Either Derek was not being heard when expressing his difficulty in looking after Dorothy or he was being stoical and downplaying the difficulty that he was in. Without talking to the family this cannot be further explored. Either way, those undertaking assessments need to be mindful of the difficulty for carers and that they may not be giving the full picture. This emphasises the importance of engaging with the wider family as necessary.

10. Recommendations

1) That agencies ensure that they can provide appropriate support for carers in the lead-up to their loved ones moving to residential care and that support continues to be available to the person who provided care once a person has been placed in residential care.

2) That GPs refer to the Dementia NICE pathways so that they follow good practice to do carers' assessments. Carers should be invited to health reviews yearly and to also review how this is affecting their physical and mental health.

Appendix A

Kent & Medway Domestic Homicide Review

Victim – Dorothy Walton

Terms of Reference

1. Background

1.1 In April 2018, police officers attended Town A, Kent. They found that the victim had died by strangulation.

1.2 Derek Walton, husband of Dorothy Walton was also found deceased at the property having apparently taken his own life by hanging.

1.3 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 10th May 2018. It confirmed that the criteria for a DHR have been met.

1.4 That agreement has been ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office has been informed. In accordance with established procedure this review will be referred to DHR.

2. The Purpose of DHR

2.1 The purpose of this review is to:

i. establish what lessons are to be learned from the domestic homicide of Dorothy Walton regarding the way in which local professionals and organisations work individually and together to safeguard victims;

ii. 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;

iii. apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate;

iv. 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;

v. contribute to a better understanding of the nature of domestic violence and abuse; and

vi. highlight good practice.

3. The Focus of the DHR

3.1 This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Dorothy Walton.

3.2 If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

3.3 If domestic abuse was identified, this review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

4. DHR Methodology

4.1 Independent Management Reviews (IMRs) must be submitted using the templates current at the time of completion.

4.2 This review will be based on IMRs provided by the agencies that were notified of or had contact with Dorothy Walton in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Dorothy Walton or the perpetrator, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

4.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR must include all information held about Dorothy Walton and Derek Walton from 1st November 2016 to her death in April 2018. If any information relating to Dorothy Walton as the victim, or Derek Walton being a perpetrator, or vice versa, of domestic abuse before 1st March 2017 comes to light, that should also be included in the IMR.

4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Dorothy Walton and/or Derek Walton. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2010, X was cautioned for an offence of shoplifting).

4.6 Any issues relevant to equality, i.e age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation must be identified. If none are relevant, a statement to the effect that these have been considered must be included.

4.7 When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Chair of the panel. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

5. Specific Issues to be Addressed

5.1 Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

i. Were practitioners sensitive to the needs of Dorothy Walton and Derek Walton knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Dorothy Walton and/or Derek Walton (as applicable)? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools,

procedures and policies professionally accepted as being effective? Was Dorothy Walton and/or Derek Walton subject to a MARAC or other multi-agency fora?

iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

ix. Was this information recorded and shared, where appropriate?

x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

xi. Were senior managers or other agencies and professionals involved at the appropriate points?

xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

xiii. Are there ways of working effectively that could be passed on to other organisations or individuals?

xiv. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Dorothy Walton and promote their welfare, or the way it identified, assessed and managed the risks posed by Derek Walton? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

xvi. Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?

xvii. How accessible were the services to Dorothy Walton and Derek Walton (as applicable)?

Appendix B

Glossary

CCG	Clinical Commissioning Group
DoLS	Deprivation of Liberty Safeguards
GP	General Practitioner
DHR	Domestic Homicide Review
IMR	Independent Management Review
MCA	Mental Capacity Assessment
SATEDA	Support and Action To End Domestic Abuse