SOUTHWARK COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

ROSE AGED 69

MURDERED IN JULY 2018 IN SOUTHWARK

REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM

15 SEPTEMBER 2020

Community Safety Partnership – London Borough of Southwark
Domestic Violence Homicide Review Panel
Rose aged 69, murdered in Southwark in July 2018

LIST OF CONTENTS

Community Safety Partnership – London Borough of Southwark
Domestic Violence Homicide Review Panel
Rose aged 69, murdered in Southwark in July 2018

INTRODUCTION

1. One morning in late July 2018, police were called to a terraced house in Southwark by a neighbour who heard shouting. The body of Rose (not her real name) aged 69, was discovered in the upstairs bedroom. She had died from multiple stab wounds to the chest. Also present in the house was her husband, Edward (not his real name) aged 73 who had superficial stab wounds to his torso. He was arrested and charged with murder. Following a trial at the Central Criminal Court in January 2019, Edward was convicted of murder and sentenced to life imprisonment with a minimum of 15 years to be served.

2. This report of a domestic homicide review examines agency responses and support given to Rose prior to her murder. 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.

3. The key purpose for undertaking Domestic Homicide Reviews (DHR) is to enable lessons to be learned from homicides where a person is killed because of domestic violence. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

4. One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with the 'voice' of Rose at the heart of the process.

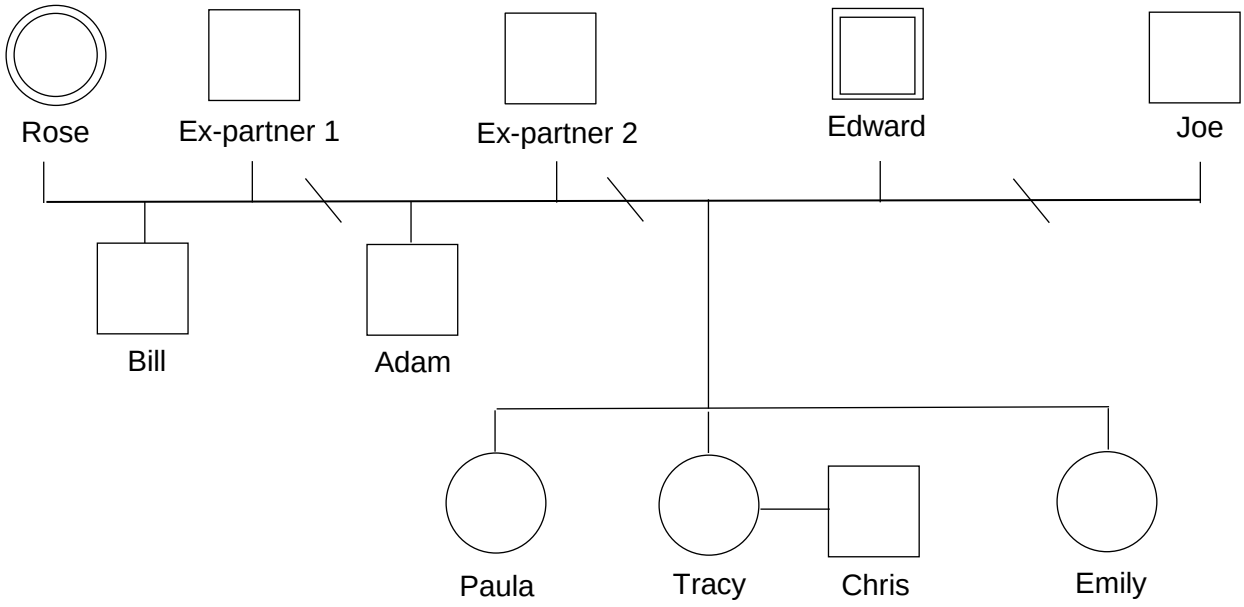
TIMESCALES

5. As soon as the homicide was reported to Southwark Council, partners were requested in August 2018 to secure all relevant records of contact with the couple in preparation for a DHR. The review began with a Panel meeting in November 2018 when Terms of Reference (ToR - Appendix 1) were agreed and Chronology reports commissioned from all identifiable public and voluntary bodies that may have had contact with Rose and Edward. Following the trial conclusion and second meeting in February, revised ToR were drafted and Individual Management Reviews (IMR) commissioned from agencies that had relevant contact with those involved. A first draft of an overview report was considered in April; the second in May and a fourth version in July 2019. With the consent of the CSP, a fifth version was shared with family members, comment invited and any difference of opinion recorded in the final version that was agreed by Panel members at their sixth meeting and presented to the Community Safety Partnership Sub-Group on 5 July 2019. With the benefit of feedback from the Home Office Pre-Quality Assurance Assessment in August 2020, a seventh version of this overview was provided for consideration by the Home Office Quality Assurance Panel in September 2010.

CONFIDENTIALITY

6. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

7. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. The deceased and perpetrator will be referred to by their pseudonym as appropriate to the narrative. Pseudonyms also will be used for their five children, a son-in-law and Rose's partner[1] in the genome below who provide most of the background information available. They are also listed in the glossary at the end of the report.



8. The Government Protective Scheme (GPMS) was adopted throughout with a rating of ''Official-Sensitive' for shared material. Either secure networks were in place (gsi, pnn) and adopted (cjsm) or papers shared with password protection. A copy of chronologies and IMRs was provided to all Panel members for review and discussion.

TERMS OF REFERENCE

9. Following discussion of a draft in the first Panel meeting, the ToR at appendix 1 were issued on the same day with a chronology template for completion by agencies reporting contact with those involved. The main lines of inquiry were:
   1. Scope of review agreed from January 2013 to date of homicide (following Panel debate initially set at five years) with any earlier event of significance to be included
   2. Identify relevant equality and diversity considerations, including Adult Safeguarding issues

[1] Each had been invited to nominate (or, if declined, were allocated) a pseudonym for the redacted report

3. Establish whether family, friends or colleagues want to participate in the review. If so, to ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it. It was noted that the Chair had established contact through AAFDA (Advocacy After Fatal Domestic Abuse) with female members of the family and that there was a difference of opinion with male members of the family and a separate channel of communication would be needed
4. Take account of previous lessons learned in LB Southwark
5. Identify how people in the LB of Southwark gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague.

METHODOLOGY

10. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Violence Homicide Review (DVHR) was commissioned by Southwark Community Safety Partnership and, in November 2018, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DVHR Panel and report author. Tony Hester supported him throughout in the role of process manager and Secretary to the Panel.

11. This review was commissioned under Home Office Guidance issued in December 2016. Attention was paid to the cross-government definition of domestic violence and abuse and is included in the Terms of Reference (appendix 1).

12. The following policies and initiatives have also been scrutinised and considered:
    - HM Government strategy for Ending Violence against Women and Girls 2016-2020
    - Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016
    - Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
    - London multi-agency safeguarding adults policies and procedures 2015
    - HMIC (Her Majesty's Inspectorate of Constabulary) Reports: 'Everyone's business: Improving the police response to domestic abuse' 2014 and 'The Metropolitan Police Service's approach to tackling domestic abuse' 2014
    - Southwark Council website and related services

13. In addition, the Chair has studied one prior DHR report commissioned by Southwark for any parallel lessons or repeat lessons to be learned.

INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

14. On appointment, the Chair discovered that Tracy and Emily had made contact with AAFDA (Advocacy After Fatal Domestic Abuse), a source of family support recommended by the Home Office in their DHR information leaflet for family members, and a meeting with the

Chair was organised in advance of the trial. Their concerns, that were primarily about actions by agencies post the homicide, including Edward's deteriorating health whilst in custody, were noted. A brief second meeting was held at the trial in January 2019. A further meeting to share the second draft of the overview and seek their input took place in June and the Chair was handed a letter that related to issues post the fatal incidents. This was passed to the Metropolitan Police for consideration.

15. In the course of the trial, it became apparent that there was a difference of opinion between the two brothers and two of the sisters regarding treatment by their father when children and what they had witnessed in their parents' relationship. Subsequently, their input to the review process was separately managed and a joint meeting with the brothers took place in July. The Home Office leaflet was provided and attention drawn to the advocacy section. They pointed out that much of what they experienced as bullying and abuse from Edward occurred when their sisters were not present. They also acknowledged that their recollections of family life could be different due to their sisters being younger. Both family groups were provided with access to the 5th version of this report during August and their comments incorporated, as well as their choice of pseudonyms. It remains a fact that the views expressed in this review are not shared by all family members.

16. Rose's partner, Joe agreed to meet the Chair in May. The Chair wrote to the Governor of the establishment where Edward is incarcerated and interviewed him in June. Rose and Edward were both retired and they did not socialise with neighbours. Their social life revolved around family and a local Social Club ran by Chris and Tracy and they had friends that knew them well. Rose had been friends with a close neighbour for more than 20 years but she did not respond to an invitation to participate. Rose and Edward had more contact with the children of their daughters and enjoyed a close relationship with them.

17. The caveat on the information that is set out in the narrative and analysis sections that follow is that much of it derives from interviews with family members, as well as the police investigation, as confirmed in evidence adduced at the trial. The learning from the review is better informed by these insights, but it may be challenging for family members to read what has been disclosed about their relationship experiences and what they may have reasonably expected to remain private family matters. The importance of inclusion of such matters is aligned to the primary purpose of DHRs, to provide understanding so as to improve the system for safeguarding in future.

18. It is a terrible situation for a family to endure when one parent is murdered by the other, who is then effectively 'lost' to them through a regime of imprisonment. Through the Chair, the Panel has offered their deepest condolences to Rose's family on their loss.

CONTRIBUTORS TO THE REVIEW

19. This review report is an anthology of information and facts from the organisations represented on the Panel, most of which were potential support agencies for Rose and Edward in the LB of Southwark. However, only the GP Practice situated in the London Borough (LB) of Lambeth reported any relevant contact prior to the fatal incident. The

Metropolitan Police Service (MPS) homicide investigation opened a window on what was happening within the relationship in the weeks leading up to the homicide.

20. Lambeth Clinical Commissioning Group (CCG) provided an IMR containing their record of contact, their analysis of what happened, identification of good practice as well as any lessons to be learned with a recommendation for improvement to the system for safeguarding. The MPS provided a letter that set out their findings from the police investigation. Both submissions were conducted by a senior manager not connected with the events and the Panel are satisfied as to their independence. The IMR and letter were the basis for the first draft of the overview report, robustly debated at the third Panel meeting and kept under review throughout the five versions of the report that were generated prior to the final version.

THE REVIEW PANEL MEMBERS

21. *Table 1 – Review Panel Members, all of whom are independent senior managers*

Name	Agency/Role
Hannah Edwards	Southwark Safeguarding Childrens Partnership (SSCP) and Safeguarding Adults Board (SSAB) Manager
Hazel Guha	Southwark Safeguarding Boards Administrator
Dr Megan Morris	Southwark CCG Named GP Adult Safeguarding
Musthafar Oladosu	Southwark CCG Designated Nurse Adult Safeguarding
Patricia Comley	LB Southwark Adult Social Care, Principal Social Worker for Adults and Strategic Lead for Adult Safeguarding
Abi Oguntokum	LB Southwark Housing Area Housing Manager, Southwark Council
David Rowley	Lambeth CCG Designated Nurse Adult Safeguarding
Heather Payne	Head of Adult Safeguarding Kings College Hospital NHS Foundation Trust
Emma Sharp	Detective Sergeant, MPS Serious Crime Review Group

Amy Glover	Senior Manager – Community Services Solace Women's Aid
Bill Griffiths	Independent Chair and Author of report
Tony Hester	Independent Manager and Panel Secretary

AUTHOR OF THE OVERVIEW REPORT

22. Bill Griffiths is the author of the overview report. He is a former police officer who last had operational involvement in LB Southwark in 1993. He has been appointed as the independent Chair of the DHR Panel having had no involvement in policing since retirement from service in 2010. Set out for reference in appendix 2 are the full respective backgrounds and 'independence statements' for Bill Griffiths and Tony Hester who managed the review process and liaison with the CSP and Panel. Since 2013, they jointly have been involved in more than twenty DHRs.

PARALLEL REVIEWS

23. The Criminal Trial concluded in January 2019. An Inquest was opened by the Coroner and closed following the murder trial and verdict. There were no known misconduct issues to be investigated.

EQUALITY AND DIVERSITY

24. Consideration has been given to the nine protected characteristics under the Equality Act in evaluating the various services provided. Both Rose and Edward are of pensionable age and are White British by race. Rose is female and they were married. There is no information as to their religion or belief. From GP records there is no evidence of disability but some evidence that Rose suffered from depression and Edward reported being "stressed" at times, including in the days leading up to the homicide. Their respective health records are fully examined in the background information section. The Panel concluded that there was no evidence of disparity or inequality in public services provided. There is no information available regarding how Rose and Edward perceived services.

DISSEMINATION

25. The intended recipients of copies of this report, once approved by the Home Office Quality Assurance Panel, are listed at the end of the review after the glossary.

BACKGROUND INFORMATION (THE FACTS)

26. *Table 2 – Summary of key events*

Date	Event
1963	Rose and Edward met as part of same social group. Rose was pregnant with Bill
1965	They met again when Bill was aged 2 and Mark was just born
1966	Rose and Edward married when Rose was pregnant with Paula. Two further daughters, Tracy and Emily, followed
1972	Family allocated local authority three-bedroom house & parents remained married for 52 years
1975	Rose met & had brief affair with Joe, friend of Adam's father. They met up again in March 2018, renewed affair & were partners at time of fatal incident
1994	Bill was contacted by his biological father but did not disclose this to Rose and Edward
1998	Edward retired from job as refuse collection driver due to back injury but made objects for sale from re-cycled wood
2000	When also working for Bill at his café business, Edward found out about the contact from Bill's biological father in 1994 causing a major rift between them and Bill asked Edward to leave his employ
2000	Six months later Bill received a series of 'nuisance calls' late at night in which the caller would hang up. After about three months, the family managed to block the caller and this transpired to have been Edward. The behaviour was reported to police for record purposes & the problem ceased
2008	The GP Practice for Edward conducted a physical health review for him that recorded he would: "get very stressed about things"
2015	The same GP practice for Rose had nine contacts for routine matters including tiredness and fatigue
2017	Rose admitted to KCH for a broken humerus and damaged shoulder caused by a fall when on a bus. Investigated by Panel and injury consistent with a fall and no DA suspected
2018	Edward waiting for procedure to restore normal heart rhythm
March	Rose made contact with Joe through Facebook and their affair was re-kindled
May	Rose disclosed the affair to Paula
June	Edward overheard Rose talking to Joe over the telephone and confronted her. He told her to leave, she packed a bag and left. Edward visited Tracy who noted he was "shaken & upset"
2-19 July	Edward conducted web searches on gun shops, geo-mapping, electoral register (regarding Joe's home address), large storage bags and cemetery sites. He asked Chris for help with locating Joe's address but Chris provided misleading information

10 July	Rose made return visit to collect belongings whilst Joe waited nearby in his car. Edward covertly made an image of Joe's contact details from Rose's phone
12 July	Edward approached Pharmacist at GP Practice for sleeping tablets & a short course was prescribed for review the following week. Edward attended at the wrong time but returned the next day and prescribed zoplicione
17 July	Proposed second visit to the house to collect belongings was cancelled by Rose because Edward would be present. A visit on 24 July when he said he would not be present was arranged
18 July	Edward confronted Bill at the social club blaming him for the marriage break-up. Subsequently, Rose contacted Bill to say that Edward wanted to apologise but this did not happen because Bill declined to provide his mobile number
In the week prior to the homicide	Edward approached CD to acquire a firearm which was declined and Edward twice called again with the same request
23 July	CD expressed concerns to Chris but he did not pass on the information because CD was affected by alcohol and he did not believe Edward would be violent toward Rose
24 July	Rose called at house to collect belongings while Joe waited nearby. Edward mounted fatal attack

Background provided by family and friends

27. The reader is reminded that the narrative that follows would be very limited had not family members, Rose's partner and Edward himself, disclosed information about intra-family experiences that were not in the public domain until revealed in the course of Edward's trial for murder. Inclusion of these insights in this overview report is for the sole purpose of understanding what happened so as to improve the system for safeguarding.

28. Rose and Edward first met in 1963 when they were part of the same social group of young people. Rose was 15 and pregnant with Bill. When they met up again, Bill was 2 and she had just given birth to Adam with a different father. They married in 1966 when Rose was pregnant with their first daughter, Paula, and they went on to have two more daughters, Tracy and Emily. From September 1972, they were provided with a Southwark Local Authority three-bedroom terraced house at the end of a quiet residential cul-de-sac. Police local enquiries indicated that the couple generally were private people who kept themselves to themselves. They remained married for 52 years.

29. Rose is described by her daughters as *"young at heart"*. Her sons said she was outgoing, *"nothing was too much trouble"*, particularly concerning her children, and that kindness extended to children in the neighbourhood. Partner Joe said she was *"generous and very kind to others"*. He added that when Rose was unhappy in the relationship with Edward, she considered it none of anyone's business and she would *"smile to cover it up"*.

30. Rose was the homemaker and mother of five for much of the marriage with Edward. Then, up to 2009, she was employed locally for several years to care for an elderly woman who, on passing away, acknowledged Rose's quality of care in her Will. This is relevant because, not only was Rose subsequently generous with her children, the legacy made her financially independent from Edward and they had individual bank accounts, information that he volunteered to the Chair. Rose also undertook casual work in a café and would provide a weekly clean at Tracy's flat.

31. Edward worked as a refuse collection driver for Lambeth Council from 1972 until he was medically retired in 1998 due to a back injury. He then worked from home, engaged in delivery of sawdust to butchers shops and making wooden items, such as rabbit hutches, to sell. Since 2016, he has helped out his daughter Tracy and her husband Chris at the Social Club they run, by cleaning and supporting large events. He enjoyed watching and gambling on horse racing.

32. Edward is described by his daughters as *"old school"*. For his stepsons, this manifest in strict discipline so far as they were concerned, because their sisters could do no wrong in his eyes. One example provided by Bill is being made to stand on one leg, facing the corner for a long period. Edward acquired odd items from his work in refuse collection, including a horse whip, and would crack it if Bill's other leg moved. Both stepsons remember that Edward also had a bull whip which he never hit them with, but he held out the threat by cracking it behind them, while chasing them round the house in a 'game' that he seemed to enjoy. His daughters recall that any misdemeanor on their part was dealt with exclusively by their mother.

33. As a couple, their social life revolved around the Social Club. Neither was seen to drink to excess there or at home. At Rose's suggestion, she moved into the spare bedroom some ten years earlier and Edward says he was *"not bothered"* by this. As a family, they would holiday together, travelling around Europe, settling on Cyprus from about 1988 as their preferred holiday destination and they made friends there. After a few years, Rose would take separate holidays, usually with her daughters and grandchildren. Again, Edward says he was unconcerned as he did not enjoy the heat anyway and chose to stay at home.

34. Edward knew that Rose was *"seeing people from time to time"*, however, he professed that his love for her meant that he *"let it go"*. Joe, who had known Rose when she was with Adam's father, bumped into her in 1975 and they embarked on an affair, which she ended[2]. Edward confronted another man he suspected in about 1980 and he *"disappeared"*. Rose twice left Edward in the 1970s/80s in connection with affairs and he recalls she also overdosed herself on at least two occasions, once when they were living in Camberwell and an ambulance was called, and once when his sister found Rose outside the house in Lambeth[3].

[2] Edward did not know about this until revealed at his trial
[3] It has not been possible to verify this from archived paper medical records

35. In the course of the homicide investigation, their children were interviewed and described their experiences growing up[4]. Bill, the eldest son, regarded Edward as his father until aged about 13 when he learned about his biological father and he sensed that Edward's attitude toward him changed. He does not recall Edward ever showing him affection or give praise, rather, he would often belittle him.

36. Bill's abiding memory is that Edward's mood was unpredictable. When in a bad mood, he would come home and start picking at things, for example checking that Rose had cleaned properly by running his finger along the top of a door. He would shout, bang the table and slam doors. He would sometimes punch the door, breaking the upper panel[5]. He would pick an argument with Rose who would argue back but he would keep on at her until she gave in and would then have to apologise. Bill did not witness any physical assault.

37. In 1994, Bill was contacted by his biological father, who is of Turkish Cypriot heritage, who simply appeared one day at his front door. Bill did not allow this to develop further and, out of respect for his mother and stepfather, he did not disclose the encounter to them. By 2000, Bill was married and owned a café business in which both Edward and Rose worked. Edward found out from a chef at the café, who knew Bill's father, what had happened six years earlier. Bill was not aware of the chef's disclosure but noticed that Edward was hardly speaking to him yet would make sarcastic comments to customers within earshot. After two months, Bill asked Edward to leave because of the negative atmosphere. The chef then owned up to having made the disclosure. Tracy described Edward as *"broken"* when the chef relayed the story. Edward acknowledged to the Chair that, because Rose also worked there at the time, he was *"suspicious and jealous"* that she might be seeing Bill's father again. The fraught situation certainly caused a major and enduring rift between Edward and Bill.

38. Within about six months of that, Bill's family started to receive nuisance telephone calls during the night over a three-month period. The phone would ring and disturb sleep, then ring off before it could be picked up. One night, the family waited and picked up at the first ring, which gave a connection so that the telephone company could place a bar on the number from making further contact. Bill suspected the caller had been Edward and this was confirmed when he asked his sister Paula to call his home number from Edward and Rose's family home and it was blocked. He challenged Edward to which he responded that Bill should *"Watch his back"* and *"This is not the end of this, just the start"*. He also said: *"I wanted to make you feel how I felt".* Bill's wife reported the matter to local police in September 2000 so that there was a record in case of further trouble. There was no police investigation and the behaviour stopped.

39. Knowing how upset Rose was by this rift, Bill approached Edward on a number of occasions to try to draw a line under things. At his sister's engagement party, he said to Edward: *"We can't go on like this"*, to which Edward replied: *"Well I can!"*. Edward told the Chair that Bill tried, repeatedly, to *"patch things up"* and went on to acknowledge: *"I was stubborn"*, an attitude, that he now regrets, that he held for 18 years.

[4] And both brothers and two sisters were separately interviewed by the Chair
[5] His sisters recall this happening only once

40. Second son, Adam, considered Edward as his father but felt that he and Bill were treated differently because they were not Edward's biological children. He has a happy memory of early-morning fishing with Edward as they shared a passion for the sport. However, his overriding recollection is of Edward as an angry man; he would often shout and *"explode with anger*" banging the table or door, which made Adam fearful of personal violence. When his sisters were out with Rose, Edward would 'play-fight' with the boys but it would result in them being painfully *"tied in knots"* until tears emerged.

41. Once or twice, he remembers Edward physically kicking him up the stairs. Adam recalls that, when aged 5-7 years, his father would lock him in the coal cupboard under the stairs, then scratch on the door whilst he was trapped inside. This would terrify Adam as he was scared of the dark and Edward knew it. Adam eventually brought a halt to this abuse by shouting *"I know who it is"*. Adam did not witness violence towards his mother but he felt Edward was controlling of her. Adam left home as soon as he could because of his father.

42. Eldest daughter, Paula, described her mother as the matriarch of the family. She moved away to the Isle of Wight and her mother would stay there for holidays. Middle daughter, Tracy, said that, like any family, they had issues over the years and her mum and dad would argue. She recalls her mum walking out on her dad when she was about 10 years old[6] but returning and everything was fine. She does not recall any violence between the couple but does remember Edward banging things when he became angry. Rose would often go on holiday with Tracy while Edward stayed at home.

43. Youngest daughter, Emily, described her parent's relationship as *"normal"*. They argued but she never witnessed any violence between them. Emily did not have a conversational relationship with her father; it was almost as if they did not know what to say to each other. That said, Emily is clear that Edward was always on hand to help her when needed and was a *"great"* grandfather to her children who love and miss him very much.

Background from the GP Practice IMR

44. Both Edward and Rose were registered as patients at a Group Practice in the adjacent Borough of Lambeth for the period under review, 2013-18. A chronology of contact was compiled and a reflective discussion held with the IMR author (Panel member), the Practice GP Partner and the Southwark Named GP for Adult Safeguarding (Panel member) to review what information was revealed in the chronology, what lessons may be drawn and identify recommendations to inform the IMR.

45. Prior to the review period, two GP records were identified as possibly relevant with respect to Edward. In a physical health review in September 2008 it was recorded that: *'Patient gets very stressed about things'*. A subsequent review in May 2009 noted: *'Friend recently passed away; under some stress'*. Both disclosures were made during reviews of an unconnected physical health complaint. There is no indication that these disclosures should

[6] Adam also recalls Rose left home in 1979, confirmed by Edward

have led to further signposting or support; the GP had followed appropriate clinical guidelines.

46. In 2013, Rose had eleven contacts with the practice, mainly in connection with mild physical health complaints, including Restless Legs Syndrome, Irritable Bowel Syndrome and generalised muscle pain. These contacts were managed appropriately in accordance with clinical guidelines. In the same year, Edward had six contacts for medication reviews and other routine physical health related consultations. 2014 was also unremarkable with nine and eleven routine contacts, respectively.

47. In 2015, Rose had nine routine contacts predominantly in relation to mild physical conditions, these conditions potentially also having associated psychological factors as either a cause or effect. In March, Rose saw the GP in relation to episodes of vertigo. This was reviewed two weeks later, when she disclosed that she was fatigued, as well as being anxious and stressed due to: *'two daughters planning to be married in the summer'*. In October, Rose again saw the GP due to feeling tired and fatigued. In November, following tests, she disclosed she thought she may have low level anxiety / depression. Talking therapy was discussed but declined. These contacts were managed appropriately in accordance with clinical guidelines. In the same year, Edward had five contacts consistent with his minor health complaints.

48. During 2016, Edward did not visit the practice, whereas, Rose had ten contacts that included a review of her vertigo / dizziness in March. There were no further contacts until September, when she requested a prescription prior to traveling abroad. In November, she complained of low back pain and the GP prescribed painkillers.

49. 2017 was mainly unremarkable so far as the GP Practice was concerned, with ten contacts for Rose with lower back pain, reported by her not to be related to any trauma or falls. She was offered painkillers and physiotherapy. Edward had six contacts in relation to existing chronic physical health complaints, as well as the development of a moderate physical health condition.

50. In early December 2017, Rose was admitted to Kings College Hospital (KCH) following a fall on a bus that had caused a broken humerus and damaged shoulder. She attended follow-up appointments at the fracture clinic and was seen in the GP Practice in February 2018 for ongoing shoulder pain. Physiotherapy at KCH continued until June. She also complained of feeling *'lightheaded'* for three weeks and blood tests revealed a vitamin deficiency. Rose's further GP consultations in 2018 were for mild physical health complaints, the last in March.

51. At the Chair's request, the hospital notes for the broken arm have been reviewed by the KCH Emergency Department Consultant and Safeguarding Lead and the injuries are consistent with the mechanism of injury given. While another cause, such as assault, cannot be ruled out, staff had no reason to suspect domestic abuse. They are trained in DA and an IDVA (Independent Domestic Violence Advocate) is available on site for a referral if DA is suspected. Family members have confirmed their belief that the cause of the injury was accidental and the matter was not raised in evidence at the trial.

52. In 2018, Edward had ten GP contacts, mainly for medication reviews and other routine physical health related consultations. His daughters disclosed to the Chair that he had been waiting for a procedure they knew as *"stopping his heart"* in August and the worry of this contributed to his state of mind. Medically, the procedure is known as *cardioversion*, the procedure aiming to restore a normal heart rhythm. Whilst recognising both the concern on the part of the family, and the natural feelings of worry that Edward would have been feeling prior to the cardiac procedure, there is no clear evidence that a procedure of this nature would significantly enhance the risk of violence towards others.

53. Relevant to this review is that twelve days before the fatal incident, on 12 July 2018, Edward approached the Pharmacist at the Practice and requested sleeping tablets. He disclosed a marital breakdown and his wife had left him. A short course of sleeping tablets were given and review was set for a week. Non-medical types of support were pointed out. Edward attended on 18 July at the wrong time for the follow-up appointment but returned on 19 July. The pharmacist prescribed zoplicione and encouraged good sleep behaviour. That was the last contact from Edward with the Practice.

54. When asked about this, Edward thought he had, in fact, been seen by a doctor but acknowledges that he was not in the state of mind to notice. He was *"grieving"*, feeling he was *"in a dark place"* and this caused significant sleep disruption. His main preoccupation at that time was suicide and the sleeping tablets helped calm him. Immediately after the fatal incident he took what he thought was an overdose of the medication provided.

55. The Pharmacist has been interviewed by the IMR author. The impression gained at the first encounter was that Edward was; *"Upset and broken"*. The second encounter was random, in that Edward appeared in the corridor and engaged the pharmacist in a conversation about his medication, which was *"bizarre in that it was unusual for a patient to stop the pharmacist in the corridor of the practice"*, but he seemed content to return the next day for a proper appointment. The impression gained at that appointment was that Edward seemed much calmer and his distress seemed to have improved.

56. The pharmacist is employed at the Practice and has received domestic abuse training in other practice roles. There were no DA indicators in the consultations and random meeting with Edward. The Practice has regular clinical meetings to discuss complex cases and this was not raised. The Pharmacist has previously discussed DA cases with the Safeguarding Lead at the Practice and was involved in the debrief and reflection following the murder of Rose, news of which was a complete shock.

Background from the police IMR[7]

57. No criminal convictions or cautions were recorded for Edward or Rose. There was contact with the police in 2000 when son Bill and his wife reported Edward for making nuisance telephone calls, a matter that was for the record only and Edward was not spoken to by police. Edward reported minor criminal damage at the house, believed caused by local youths in 2014. In 2017, he was given words of advice for a minor aviation offence with a drone.

58. There are no other police records until the fatal incident on 24 July 2018, however, the police murder investigation has provided accounts from family members, acquaintances and neighbours. Data from the telephones for Rose and Edward was also downloaded and references will be made in the sequence of events below.

59. In March 2018, Rose made contact with Joe through Facebook. They had known each other as teenagers when they had a brief relationship. Joe was also the friend of AB, deceased, biological father of Adam. When they met by chance in 1975, they had a brief affair which Rose ended. Following the Facebook contact, the affair was rekindled. Rose confided in Joe that she had been unhappy in her relationship for 40 years. More recently, she found a letter from another woman addressed to Edward stating that she was due to have his baby.

60. Rose wanted to leave Edward but felt constrained due to the things going on in her life. She did not tell Joe that Edward had been violent to her but described one occasion when he smashed a door down[8]. She said Edward was a jealous man who did not trust her. She added that they had separate bedrooms at home and hardly spoke to each other. Another family member disclosed to the Chair that Rose had confided she could never leave Edward because: *"He will come after me"*.

61. In May, Rose disclosed the affair with Joe to her eldest daughter, saying that she did not intend to leave her father. Paula agreed not to tell other family members. Later that month, or in early June, Rose also disclosed the affair to daughter Emily whom she would visit each Friday. She described how unhappy she was in the relationship with her father and went on to say that she was in love and had not ever felt like that.

62. In late June, Rose told Joe that Edward had overheard her talking to him on the phone. Edward's account is that he had spent the evening at the Social Club, returning at 10pm. He noticed Rose's silhouette at her bedroom window and she was speaking on the telephone. As he entered her room, she looked embarrassed and ended the call as if it were to daughter Emily. It was later than usual for such a call which made Edward suspicious. The next morning, he examined the phone and saw that the last call was to 'Joe'. He confronted her about this, saying: *"Have you been messing about?"*. Rose confessed that she had been seeing someone. Edward told her to leave, so she packed a bag, called Joe, and asked him to collect her. Rose heard Edward singing in the bath as

[7] Including perspectives from family, Edward and Joe
[8] Probably the same incident described by the children and confirmed by Edward

she left. Joe took her in, albeit, he felt *"not ready"* as he was still grieving over the loss of his wife. Edward then visited daughter Tracy and disclosed what had happened. She noted he was extremely shaken and upset.

63. Tracy confronted her mother angrily over the phone. Rose apologised to her, said that she did not love her dad and confirmed she was in a relationship with another man. Tracy pointed out that Edward was distraught and wanted Rose to return home. Tracy did not then see her mother but told her that she was devastated and loved and missed her.

64. Later, Rose informed Bill about the breakup. She said she was the happiest she had felt in years. Her son was pleased for her and had felt she deserved better. On 5 July, she sent Bill a text asking to see him. She felt lost and nobody was talking to her. They met on 6 July and Rose explained that she had arranged with Edward to collect her belongings from the house on Tuesdays (the first had been on the 3rd). Bill was uneasy about this, fearing that Edward would *"kick off"*, and offered to accompany his mother. She declined, saying that Edward had been amicable with her.

65. Between 2 and 19 July, Edward conducted web searches on gun shops in the local area on six days. He appeared interested in used shotguns and guns with silencers. He told the Chair that his interest in firearms was as a means to suicide. On 3 July, he downloaded three applications that provided enhanced geo-mapping and street views. On the same day, he used the 192.com electoral register website (a source he had gleaned from listening to Tracy's husband Chris in conversation with a family member) to search on two half postcodes and re-visited the site on numerous occasions up to 18 July, including on the 14th to register for enhanced information.

66. On 7 July, Rose informed Adam by telephone about the new relationship, how happy she was feeling and that things were amicable. He was pleased for her but not surprised because Tracy had earlier informed him of the separation. There had also been a separation he recalled in 1979 and he assumed this time it was because of his father's controlling behaviour. Adam had no further contact with his mother as was generally distant from the family.

67. That day, Edward made web searches for sources of sofa storage bags and large builders bags. Daughter Tracy has suggested that planned purchases of furniture and a refurbishment to the kitchen could account for these searches. He also searched for free wild swimming locations. On 9 July, he researched Southwark Council website for information about Nunhead Cemetery and also looked at it on Google Maps.

68. On Tuesday 10 July, by arrangement with Edward, Rose made her second return to the house to collect belongings. Afterwards, Rose informed Joe that these visits were very unpleasant and she was receiving *"a lot of angry verbal"* from Edward about his feelings. This is not consistent with what she had revealed to son, Bill, who has reflected that this was because she did not want to make matters worse with Edward by telling her son. Edward's telephone was subsequently found to contain an image, taken at the time of the visit, of Rose's phone screen on which Joe's contact number is displayed.

69. On Tuesday 17 July, Edward was supposed to be out with his daughters so that Rose could visit the house to collect belongings. According to Joe's understanding, Edward cancelled this planned visit on the day, so Rose decided not to go to the house.

70. Bill happened to be working at the Social Club on 18 July and Edward visited. Bill said he was sorry for the way his mother had done things. Edward reacted angrily and blamed Bill for instigating the breakup in the marriage and accused him of colluding with Rose and Joe, saying: *"You know more"*. Rose called Bill on the 20th to say that she had heard about the altercation and had challenged Edward about it, as had his sisters, and he wanted to contact Bill to apologise. Due to his prior experience, Bill declined to share his mobile number with Edward and the offered apology did not happen.

71. Post the separation, Chris, had seen Edward *"almost every day"* at the Social Club that he runs. Edward was clearly depressed, would often cry in his presence and would telephone him at odd hours, day or night. Edward asked Chris if he would help him find out where Rose was living so that he could *"see if it was OK"*. Chris did find out but gave Edward the incorrect address. Edward also asked Chris if he could borrow a car, as he did not want his car to be seen outside of the address.

72. Subsequently, Edward confronted Chris very angrily, shouting and swearing at him for giving him the wrong address. Chris realised that he had been there so he then provided Edward with an area location and part postcode for Joe's address, insufficient to enable closer identification. Chris knew how to locate Joe's address, was only pretending to assist Edward and was pleased to mislead him. Chris asked Edward if he was going to do anything stupid and he reassured he was not. Later, Edward said things to Chris that made him think he wanted to harm Rose. He put this down to depression and anger at the breakdown and did not think he would actually do anything. Edward spoke about going to a cemetery to see where he could dump a body and then kill himself. Chris suggested he should consult a doctor and Edward apologised. It is not known if this conversation led to the GP Practice visit on 12 July when Edward saw the pharmacist. Edward's suicide ideation was the main concern for Tracy and Emily.

73. About a week before the homicide, CD, who knew Edward and Rose from the Club since about 2016, was approached by Edward in a local public house, saying he had a problem and needed help. Edward asked CD if he could acquire a gun. He looked serious. CD said he could not and asked if he was being threatened by anyone. Edward did not respond and left the pub. Edward called CD twice after that, on the 20th and 22nd, with the same request.

74. At about 10pm on the evening of 23 July, CD called on Chris, disclosed that Edward had asked him if he could acquire a gun and expressed his concerns about the state of the relationship between Edward and Rose. CD assured Chris he could not and would not carry out the request. CD was visibly affected by alcohol at the time and Chris did not impart this information to Tracy or anyone else as he also did not believe that Edward would do anything violent to his wife. Chris was unaware of Rose's plan to visit the home the next day to collect more of her personal belongings.

75. That same evening at 18:38, Rose received a WhatsApp[9] call from Edward that was immediately terminated so she called him back. Joe says that Edward informed Rose that he would not be there the next day when he had agreed she could collect what Joe understood would be the last of her belongings[10]. Within a minute, he returned the call to check that she had the keys to the house for access. This may not be unusual because Emily's view is that Edward would often accidentally call family members on WhatsApp that would then cut off and he would be called back.

76. Rose informed Joe that Edward's mood seemed much lighter. Stepson Bill later ascertained from Edward's sister that she had spoken to him that day and was more *"upbeat"* than before. Given the social media evidence, it is possible that Edward had planned to provide Rose with a false sense of security and, maybe, had also hoped that Joe would attend to help her. Emily's strongly held view is that Rose would have been respectful to the home and not invited Joe inside.

The fatal incident

77. On a Tuesday morning in late July 2018, Joe dropped Rose near to her marital home in order to collect more of her belongings, then waited in his car out of sight as he had done twice before. After an hour, she had not returned so Joe visited the house to see emergency vehicles outside, so then went to the Social Club to see Tracy (who had not met him before) and raise the alarm.

78. Meanwhile, a neighbour, who could hear a woman screaming and a male shouting, called police to the home. The informant thought that the male occupant was holding the female against her will. The male was heard repeatedly shouting at the female, demanding to know where she was now living. The male was also heard shouting that he was going to: *"Break her neck".* The informant reported hearing several thud sounds coming from inside the house before it went quiet.

79. Officers arrived on scene within seven minutes of the call and were not able to gain entry. The front door was secure and there was no response to repeated knocking. No sound was emanating from within. The officers made their way to the rear of the property via a side alleyway, which led to the back garden. The garden gate was closed, but upon looking over the fence, they could see that the rear door was open. A male was seen to shut the door.

80. They forced entry to the rear garden via the garden gate, at which point the male came to the back door and opened it. The male was the occupier, Edward. He had visible stab injuries to his abdomen and lower chest, his hands were covered in blood, as was his clothing, and he also had what appeared to be blood splatter on his neck. Edward was

[9] A telephone application that provides end-to-end encryption and content is not recoverable
[10] This understanding is challenged by daughter Emily who says that Rose had more possessions to collect and had told her she would eventually "*need a van"*

provided with first aid to his wounds. Edward said that a female had stabbed him following a fight and that she was upstairs.

81. On making their way into the house, the officers noticed a strong smell of gas in the kitchen. It was established that the gas cooker had been turned on but not ignited, so it was switched off. Upon entry to the front upstairs bedroom, Rose was located and appeared lifeless lying face up on the floor. She had clearly suffered substantial blood loss and two stab wounds to the left side of her chest were noted along with a severe blunt trauma type head wound. The officers commenced Cardio Pulmonary Resuscitation (CPR) pending the arrival of the London Ambulance Service (LAS) who took up the CPR. Doctors from the Helicopter Emergency Medical Service (HEMS) also arrived on scene and a thoracotomy was performed, however, Rose was beyond saving. Life was pronounced extinct by a HEMS doctor.

82. Two kitchen knives and a lump of wood, all with blood on them, were recovered from the scene. Edward was arrested on suspicion of murder and said: *"OK, I don't know why you are doing this I don't want to live".* He was taken to Kings College Hospital for his injuries which were treated and he was later discharged into police custody. On the way to hospital he said: *"My ex-wife came over as she had left me. She came to collect her belongings, it got nasty and we had a fight. I used a knife from the kitchen. I don't want to live".* Whilst at hospital Edward disclosed to staff that he had taken an overdose of sleeping medication.

83. Enquiries were made in the vicinity and a neighbour reported (who also called 999) hearing the sounds of two people shouting at one another:

    Male: *"Tell me where you live"*, repeatedly becoming more aggressive each time
    Female (sounding as if struggling and in pain): *"Let me go, let go of me"*
    From the alleyway running alongside number 25 with the back door was open the informant could hear the same male: *"Tell me where you live"* repeated about 20 times, becoming more aggressive with each demand
    The female appeared to be making noises of someone trying to break free
    Male was then heard to say: *"I'm going to break your fucking neck"*
    Then, about a dozen thudding noises, followed by a female whimpering noise

84. A Post-Mortem examination noted that Rose had multiple incised injuries to her chest. Either of the two most serious could have proved fatal and at least moderate force would have had to have been used to cause one of the injuries. Either of the knives seized could have caused these injuries. There were incised injuries and fractures to the upper limbs which could be regarded as defence type injuries. There were multiple scalp lacerations which would have been as a result of blunt force impact. These resulted in traumatic brain injury which contributed to the cause of death although it cannot be stated whether these were inflicted before or after the incised injuries. A heavy piece of wood such as the one recovered from the house could have caused these injuries.

85. During interviews, Edward made no reply to all questions put to him. After a two-week trial in which he advanced a defence of 'loss of control', he was convicted of murder and

sentenced to Life Imprisonment to serve a minimum 15 years before consideration of parole.

86. In his interview with the Chair, Edward persisted with his 'loss of control' perspective, citing the fact that Rose informed him on her last visit that he was not the father to his two younger daughters. This was the 'trigger' or 'tipping point' that caused him to commit the fatal assault on Rose. He had no plan to kill her, only himself later, by taking an overdose of prescribed sleeping tablets. There is no other witness to Edward's account and it was not accepted by the Jury.

ANALYSIS

87. The ToR main lines of inquiry for the review led to these findings:
    1. Given the paucity of information known to services, it is felt that the original scope of five years was adequate, particularly as family members and the perpetrator provided much information about earlier times and the nature of the relationship that was not known
    2. Equality and diversity is dealt with in paragraph 24
    3. Notwithstanding the fundamental difference of opinion between the separate groups of siblings and with the assistance of AAFDA, family participation was sensitively handled and each group contributed to the review, as did Rose's partner, Joe. Each group also commented on the draft overview report with their views recorded. They were frank in their historical recollections of a coercive and controlling father, but did not identify any recent relationship problems or barriers in reporting abuse. However, there is some evidence that Rose lived in fear of Edward's reactions if she decided to leave him and subsequent events proved that her concern was well-founded
    4. As for previous lessons learned, the IMR carried out with respect to the GP practice in neighbouring Lambeth flagged up the need to implement the RCGP's Safe Lives guidance for General Practices and this has been extended to include the 50% of Southwark practices yet to be trained
    5. The review has identified that the assumption that risk of domestic abuse may diminish with age, length of apparently stable relationship or absence of reported abuse is incorrect and the second recommendation will result in a targeted awareness campaign

88. From the Lambeth Group Practice perspective, there were no obvious opportunities to recognise and respond to Domestic Abuse, or to suspect that Domestic Abuse was a factor in Rose and Edward's relationship. There was evidence of good continuity of care, Rose and Edward often seeing the same GP at several different consultations. The overwhelming majority of contacts for both patients were primarily in relation to routine physical health complaints, with occasional reference to minor mental health concerns such as low mood, stress and inability to sleep.

89. For Rose, when her contacts are viewed longitudinally, there may conceivably have been reason to further explore her psychological and emotional health in addition to the times she stated she was in low mood. The chronology indicated that she came to the practice regularly with minor physical health symptoms, such as back pain, which may have an associated psychological factor. The nature of these different consultations when

considered as a whole over the entire review period may possibly have suggested a longer term low mood or unhappiness, although this cannot be accurately concluded.

90. It is known that women experiencing domestic abuse are more likely to suffer from mental health problems such as depression and anxiety[11]. If indeed Rose did have a longer term low mood, it is therefore also possible that any opportunities to explore her psychological and emotional health may have plausibly included a further question being asked about her home life. However, there is no suggestion from the information available in this review that it would have been proportionate to make such an inquiry.

91. For Edward, the key contacts were in July 2018, when he requested medication following his disclosure that Rose had left him. The requests were managed appropriately by the pharmacist. Edward's contacts with the pharmacist provoke broader consideration on the multi-disciplinary nature of a modern GP practice, and how matters relating to the recognition and response of the nuanced indicators of Domestic Abuse are relevant for all practice employees.

92. The Royal College of General Practitioners (RCGP)'s Domestic Abuse guidance outlines how general practices can respond organisationally to Domestic Abuse. The guidance outlines the need for a practice Domestic Abuse pathway. At the Lambeth Group Practice there is no pathway evident. However, there is also no indication that, in relation to Rose and Edward's consultations, had such a document been in existence and known to employees that it would have been referred to.

93. Evidence from the police investigation and family interviews provide a more comprehensive picture of the wider context and the nature of Rose and Edward's relationship over 52 years. While the stepsons agree that Edward was cruel and abusive to them and he was known for angry outbursts in which he would punch, and at least once break, a door panel, in a frightening display of physical power, they did not witness actual physical abuse against Rose. There were many examples of manipulation, however, for example by picking arguments to force an apology. On their account also, Edward followed a 'divide and rule' approach between them and their sisters as a means of exercising control. The daughters have a different experience of their father and their perspective is that he was loving and kind to them and their children.

94. There is no trail of abuse reported to agencies; none of the family members suspected physical assaults, nor did Rose complain to her children with whom she was close. She did describe to Joe a loveless marriage in which she had been unhappy for 40 years and that Edward was jealous, untrusting and controlling. There is no evidence from the police investigation that this extended to financial control and it is known that Rose had access to her own funds from 2009.

95. Rose's deep unhappiness in her relationship with Edward was not disclosed to her children until the affair with Joe started in March 2018. She continued the existing 'normality' in her relationship with Edward, until the affair was discovered by Edward in late June. That Rose

[11] Source: Women's Aid website: *The Survivor's Handbook* – Domestic Abuse and your mental health

had confided to a family member that she believed Edward would come after her if she left him, could account for her not disclosing to her family and separating earlier.

96. Edward's immediate reaction was to order her out of the house. Within days he had undertaken extensive web searches for firearms and body disposal equipment and methods. In parallel, he made strenuous attempts to trace where Joe lived, enlisted the help of his son-in-law and downloaded more sophisticated web applications to aid his search. He also consulted a casual acquaintance to source a firearm.

97. The long view of the insights into Edward's behaviour during his marriage to Rose suggests that he persistently exhibited a controlling and coercive personality that would match the wider definition of domestic abuse introduced by Government in 2015 (appendix 1). From the point of their separation in late June 2018, this chronic trait became an acute focus for his actions.

98. The trial Jury did not accept Edward's defence of 'loss of control'; the opposite was probably the case: he was seizing back control in a 'journey to homicide'. There is substantive research[12] available that relationship-based homicides are rarely spontaneous and the: 'He just snapped' explanation, which suggests an immediate proximal provocation, is not supported. Schlesinger describes 'catathymic homicides' as occurring when:

> *There is a change in thinking whereby the offender comes to believe that he can resolve his inner conflict by committing an act of extreme violence against someone to whom he feels emotionally bonded*

99. A more recent study, 'Exploring the relationship between stalking and homicide', identified 'The Homicide Triad'[13], and the coincidence of three groups of characteristics, namely, the offender's emotional or psychological state, the presence of acknowledged high risk markers and the triggers which create escalation. This prompts further speculation that Edward:
    1. Had very rapidly become <u>obsessed</u>[14] with sexual jealousy
    2. And the <u>rejection</u> and perceived betrayal by Rose
    3. Had triggered the high risk markers of <u>weapons and violence</u>

100. Families do not have the professional experience and training to recognise and mitigate risk in the domestic scenario, as should be the case with safeguarding agencies. So far as this family were concerned, they were surprised and shocked by the separation of their parents after so many years of marriage but had been reassured by Rose that relations with Edward were 'amicable'. Bill spoke sympathetically to Edward but experienced Edward's anger and blame, attributed to the current situation, but probably rooted in deep-seated resentment for the contact with his biological father many years before. Edward was challenged by Rose and the daughters (but not by Emily) for this behaviour.

[12] Schlesinger 2002, Adams 2007, Monckton Smith 2012
[13] Monckton Smith, Szymanska, Haile 2017
[14] Webster dictionary: a persistent disturbing preoccupation with an, often unreasonable, idea or feeling; an idea or thought that continually preoccupies or intrudes on a person's mind

101. Chris was exposed to much of Edward's emotional state and had been enlisted in the search for Joe and Rose's location. He wanted Tracy to see that he was taking care of Edward. Chris had tried to minimise Edward's ability to find them by disclosing only half the post code he had identified. Despite his misgivings when Edward said things that made him think he wanted to harm Rose, he did not believe that Edward would actually cause her harm. When told about the efforts Edward had made to acquire a firearm on the evening before the homicide, again, he did not take it seriously and he was unaware of Rose's planned visit to collect belongings the next day.

102. Had Rose, Joe or family members identified the abusive nature of Edward's behaviour after Rose had left him, there was advice available to residents in LB Southwark. Solace Women's Aid[15] is the commissioned provider of domestic and sexual abuse services in Southwark and is open to survivors of domestic abuse aged 16+ and survivors of sexual abuse aged 14+, providing advocacy and support to survivors of all risk levels and genders. Further domestic abuse advocacy services are also provided in the borough by Bede House and Victim Support.

103. The service is widely promoted across the borough, including an emergency out of hours pathway for survivors in crisis. Domestic abuse advocates are co-located or working in partnership with services such as the police, housing, GP surgeries[16], Kings College Hospital and drug and alcohol services. Safeguarding agencies share information and work in partnership through the local MASH (Multi Agency Safeguarding Hub[17]) project.

CONCLUSIONS, GOOD PRACTICE AND LESSONS LEARNED

104. The IMR author that reviewed the Lambeth Group Practice identified two lessons emanating from the analysis, firstly, the requirement to implement the RCGP's Safe Lives Domestic Abuse guidance for General Practice, recommending a Domestic Abuse pathway, and training for all employees. Secondly, that the supervision processes available for practice staff needs to more ably support reflective safeguarding practice, which may help with the consideration of the more nuanced indicators of Domestic Abuse. These were robustly debated by the Panel members who concurred with the views expressed.

105. Good practice was also observed. Both Rose and Edward were provided with very good clinical care. The record keeping was of a high standard, providing clear information for the review. The practice records throughout the review period conveyed a sense of kindness and compassion from the practice towards both Rose and Edward. When they attended the practice, which they did regularly, they often were seen by the same practitioner. The care appeared consistent. It is felt that they probably trusted the practice and felt comfortable sharing their personal information.

[15] A Solace representative has also advised the DHR Panel
[16] The family GP Practice was located nearby in LB Lambeth and an IMR completed
[17] Established in 2014 to promote multi agency working to identify risk, improve information sharing, joint decision making and coordinated action to safeguard children and vulnerable adults

106. The IMR author has concluded that Lambeth Group Practice provided a high standard of medical care to both Rose and Edward. The care provided met clinical guidelines, and the practice ethos appeared kind and compassionate. There were no clear indications of Domestic Abuse at any of the contacts or missed opportunities to signpost Rose or Edward to associated support or intervention.

107. There is a possibility that enhanced supervision structures may have led practitioners to reflect on the more nuanced information emanating from Rose's consultation history, and which in turn may have provided a cue for being professionally curious in respect of her home life, but this cannot be concluded with any degree of certainty. The Practice need to ensure that the organisational structures suggested in the RCGP's Domestic Abuse guidance for Practice Staff are implemented.

108. The Panel have reviewed what else could have been considered by anyone responsible for safeguarding and, even with the benefit of hindsight and this review, there were no opportunities for any professional to develop concern that Rose was at risk. An oft-used metaphor of good multi-agency collaboration is 'joining up the dots' to complete an accurate picture. In this review, there were no dots to join. Nonetheless, learning is available from the circumstances revealed from the review, particularly by family members.

109. It is well established and widely understood that the point of separation in a domestic relationship presents the highest risk to the safety of the person making the decision to leave, in fact, at least 70% of domestic homicides occur at or within 12 months of parting[18]. As is frequently the case, when a 'deadline' is set (in this instance, what Joe had understood to be the final day that Rose had set for collecting her belongings[19]) the risk is considerably heightened that the decision taken by Edward on his 'journey to homicide' is enacted.

110. The possible mitigating factors noted by the Panel in discussing the separation between Rose and Edward are: the longevity of the marriage of more than 50 years and the mature age of the partners (69 and 73). However, 'Domestic Homicide of Older People (2010-2015), a comparative analysis of intimate-partner homicide (IPH) in the UK[20], suggests that likelihood is higher within the age range 60 to 90 for both victim and perpetrator. Furthermore, one in four domestic homicides in the UK involves a victim aged over 60, whereas, their presence in the population is only 18%.

111. The main strategic learning point from this review is that there is the risk of an assumption that the strength of emotions at the breakdown of a relationship somehow diminish with age or the time spent together without reported incident. As observed in this review, the opposite assumption would be more accurate and, when encountered, should heighten adult safeguarding concerns.

[18] Femicide Census Report 2018 Ingala-Smith
[19] This hypothesis is challenged by daughter Emily – see footnote to paragraph 75
[20] Dr Hannah Bows 2018

RECOMMENDATIONS

112. The IMR author has recommended that the Lambeth Group Practice should implement the RCGP's Safe Lives guidance for General Practices and, secondly, that the supervision processes available for practice staff needs to more ably support reflective safeguarding practice, which may help with the consideration of the more nuanced indicators of Domestic Abuse. This is relevant for all GP Practices in Lambeth who have not yet implemented the guidance. The Panel support this recommendation. About half of the 46 GP Practices in LB Southwark, have benefitted from a roll out of the IRIS project[21] and the Panel extend this recommendation to embrace Southwark CCG Practices that have yet to benefit from IRIS training, to implement the RCGP's Safe Lives guidance.

    Recommendation 1

    That all GP Practices in the London Boroughs of Lambeth and Southwark that have yet to benefit from IRIS training implement the RCGP's Safe Lives guidance and provide training opportunities at GP Safeguarding Lead forums and protected learning events

113. The Panel have further identified that Southwark Safeguarding Adult Board and the Community Safety Partnership Board should ensure that:

    Recommendation 2

    The understanding by professionals, families and the wider community of risk inherent in domestic breakdowns does not diminish with the age of the partners, the length of the relationship or the lack of reported abuse

114. An action plan has been developed at appendix 3.

Author

Bill Griffiths CBE BEM QPM

15 September 2020

[21] Consistent with RCGP's Safe Lives guidance for General Practices

Glossary

CCG	Clinical Commissioning Group
cjsm	Criminal Justice Secure eMail
DA	Domestic Abuse
DAI	Domestic Abuse Incident
DV	Domestic Violence
DHR	Domestic Homicide Review
DVHR	Domestic Violence Homicide Review
GP	General Medical Practitioner
gsi	Government Secure Internet
IMR	Individual Management Review
IPH	Intimate-Partner Homicide
LB	London Borough
LBS	London Borough of Southwark
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MPS	Metropolitan Police Service
NHS	National Health Service
pnn	Police National Network
RCGP	Royal College of General Practitioners
ToR	Terms of Reference

Pseudonyms

Rose	The victim
Edward	Her long-term partner and the perpetrator
Bill	Rose's son from an earlier relationship
Adam	Rose's second son from an earlier different relationship
Paula	Rose and Edward's eldest daughter
Tracy	Their second daughter
Chris	Tracy's husband
Emily	Their third daughter
Joe	Rose's partner
AB	Biological father of Adam
CD	Acquaintance of Edward

Community Safety Partnership – London Borough of Southwark
Domestic Violence Homicide Review Panel
Rose aged 69, murdered in Southwark in July 2018

Distribution List

Name	Agency	Position/ Title
Eleanor Kelly	London Borough of Southwark	Chief Executive
Cllr Evelyn Akoto	LB Southwark	Councillor for Community Safety; lead on domestic abuse
Anna Berry	Independent Chair	Southwark Safeguarding Adults Board
David Quirke-Thornton	LB Southwark	Strategic Director Children's and Adult Services
Hannah Edwards	LB Southwark	LBS Safeguarding Board
Dr Megan Morris	LB Southwark	SEL CCG Designated GP Adult Safeguarding
Musthafar Oladosu	LB Southwark	SEL CCG Designated Nurse Adult Safeguarding
Kate Moriarty-Baker	LB Southwark	Director of Quality and Chief Nurse, SEL CCG
Abi Ogantokum	LB Southwark	Housing
David Rowley	LB Lambeth	SWL CCG Designated Nurse Adult Safeguarding
Heather Payne	Kings College Hospital NHS Trust	Adult Safeguarding
Amy Glover	Solace Women's Aid	Independent Domestic Abuse Advocate
Angela Middleton	NHS England	Patient Safety Projects Manager (London Region)
Colin Wingrove	Metropolitan Police	South West BOCU Commander
Ian Howells	Metropolitan Police	Chair of Southwark Community Safety Partnership Board
Emma Sharp	Metropolitan Police	Detective Sergeant Specialist Crime Review Group
Bill Griffiths	Independent Chair	Independent Chair/Author of the Domestic Homicide Review
Tony Hester	Director Sancus Solutions Ltd	Independent Administrator and Panel Secretary
Quality Assurance Panel	Home Office	-
Cressida Dick	Metropolitan Police Service	Commissioner
Sophie Linden	Mayor's Office for Crime and Policing	Deputy Mayor
Baljit Ubhey	Crown Prosecution Service	London Chief Crown Prosecutor

Community Safety Partnership – London Borough of Southwark
Domestic Violence Homicide Review Panel
Rose aged 69, murdered in Southwark in July 2018

Appendix 1

Context of review

One morning in late July 2018, police were called to **[a house in Southwark]** by a neighbour who heard shouting. The body of **Rose** aged 69 (born 1948), was discovered in the upstairs bedroom. She had died from multiple stab wounds to the chest. Also present in the house was her husband, **Edward** aged 73 (born 1944) who had superficial stab wounds to his torso. He was arrested and charged with murder. Following a trial at the Central Criminal Court, Edward was convicted of murder and sentenced to life imprisonment with a minimum of 15 years to be served.

Purpose of review

1. Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.

2. Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including its impact on children in the home.

3. Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.

4. Apply these lessons to service responses including changes to policies and procedures as appropriate; and

5. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

6. Highlight any fast track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

Terms of Reference for Review

1. To identify the best method for obtaining and analysing relevant information, and over what period prior to the homicide to understand the most important issues to address in this review and ensure the learning from this specific homicide and surrounding circumstances is understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified [Note: Agreed at first Panel meeting on 28/11/18 that the initial scope would be from January 2013 to July 2018]

2. To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion [Note: Panel as formed for first meeting with additions from Victim Support and Lambeth CCG (if anything significant revealed from chronology)]

3. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel [Note: The criminal trial concluded in February 2019; there are no known misconduct issues; the Coroner has yet to decide on Inquest]

4. To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required [Note: Rose is female and both parties are White British. No other considerations identified]

5. To identify whether the victims or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings [Note: There is no record of Rose or Edward]

6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2015, if so, how it could be best managed within this review [Note: There are no children involved]

7. To determine whether this case meets the criteria for an Adult Case Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were 'an adult with care and support needs' [Note: There are no known Safeguarding Adult issues]

8. To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it [Note: Contact has been established through AAFDA with the female family members and a meeting held with the Chair prior to the trial. There is a difference of opinion with the male family members and the Chair is working with the Family Liaison Officer to set up a meeting (not achievable at the trial)]

9. To identify how the review should take account of previous lessons learned in the LB Southwark and from relevant agencies and professionals working in other Local Authority areas [Note: Awaits conclusion of local research]

10. To identify how people in the LB of Southwark gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague [Note: Awaits conclusion of local research]

11. To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations

Panel considerations

1. Could improvement in any of the following have led to a different outcome for Rose, considering:
   a) Communication and information sharing between services with regard to the safeguarding of adults and children
   b) Communication within services
   c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

2. Whether the work undertaken by services in this case are consistent with each organisation's:
   a) Professional standards
   b) Domestic abuse policy, procedures and protocols

3. The response of the relevant agencies to any referrals from 1 January 2013 relating to Rose and Edward. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:
   a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with Rose and Edward
   b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
   c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
   d) The quality of any risk assessments undertaken by each agency in respect of [insert names]

4. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

5. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

6. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

7. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

8. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

Operating Principles

a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2015 – see below)

b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system

c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned

d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences

e. The review will be guided by humanity, compassion and empathy with the victim's 'voice' at the heart of the process.

f. It will take account of the protected characteristics listed in the Equality Act 2010

g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level

Definition of Domestic Abuse

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Appendix 2

Independence statements

Chair of Panel

Bill Griffiths CBE BEM QPM was appointed by the London Borough of Southwark CSP as Independent Chair of the DVHR Panel and is the author of the report. He is a former Metropolitan police officer with 38 years operational service and an additional five years as police staff in the role of Director of Leadership Development, retiring in March 2010. He served mainly as a detective in both specialist and generalist investigation roles at New Scotland Yard and in the Boroughs of Westminster, Greenwich, Southwark, Lambeth and Newham.

As a Deputy Assistant Commissioner he implemented the Crime and Disorder Act for the MPS, leading to the Borough based policing model, and developed the critical incident response and homicide investigation changes arising from the Stephen Lawrence Inquiry. For the last five years of police service, as Director of Serious Crime Operations, he was responsible for the work of some 3000 operational detectives on all serious and specialist crime investigations and operations in London (except for terrorism) including homicide, armed robbery, kidnap, fraud and child abuse.

Bill has since set up his own company to provide consultancy, coaching and speaking services specialising in critical incident management, leadership development and strategic advice/review within the public sector.

During and since his MPS service he has not had personal or operational involvement within the London Borough of Southwark (since 1993), nor direct management of any MPS employee (since 2010).

Secretary to Panel

Tony Hester has over 30 year's Metropolitan police experience in both Uniform and CID roles that involved Borough policing and Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigation.

Upon retirement in 2007, Tony entered the commercial sector as Director of Training for a large recruitment company. He now owns and manages an Investigations and Training company.

His involvement in this DVHR has been one of administration and support to the Independent Chair, his remit being to record the minutes of meetings and circulate documents securely as well as to act as the review liaison point for the Chair.

Other than through this and two other reviews, Tony has no personal or business relationship or direct management of anyone else involved.

Community Safety Partnership – London Borough of Southwark
Domestic Violence Homicide Review Panel
Rose aged 69, murdered in Southwark in July 2018

Appendix 3

ACTION PLAN

Learning Point 1: The Lambeth[22] and Southwark CCGs should implement the RCGP's Safe Lives guidance for General Practices						
Recommendation	**Scope of recommendation**	**Action to take**	**Lead Agency**	**Key Milestones Achieved in enacting recommendations**	**Target Date**	**Date of completion and outcome**
1 That all GP Practices in the London Boroughs of Lambeth and Southwark that have yet to benefit from IRIS training implement the RCGP's Safe Lives guidance and provide training opportunities at GP Safeguarding Lead	All Lambeth and Southwark CCG GP Practices	Electronic dissemination of RCGP's Safe Lives Guidance to Southwark and Lambeth CCG's GP Practice Managers and Safeguarding Leads for implementation in all GP practices	Southwark CCG in collaboration with Lambeth CCG	Electronic dissemination of Safe Lives guidance	Nov 2019	Completed September 2019 - Safe Lives Guidance circulated to all GP surgeries and analysis of impact undertaken via statutory annual self-assessment

[22] Location of the GP Practice where the victim and perpetrator were registered

forums and protected learning events		Further training opportunities to be provided at GP Safeguarding Lead forums and protected learning events to ensure Safe Lives is embedded in practice and evidenced through statutory annual self-assessments.		Training at GP Safeguarding Lead forums and Protected Learning Time		Southwark GP Protected Learning Time event held Nov 2019 and attended by 220 GPs. Purpose of event was to disseminate the learning from this review to all GPs and to refresh and update GP's current knowledge on spotting the signs of DA, including asking 'sensitive' questions to encourage patient disclosure
Learning Point 2: There is the risk of a false assumption by professionals, families and the wider community that the strength of emotions at the breakdown of a relationship somehow diminish with age or the time spent together apparently without incident						
2 To increase the understanding by professionals, families and the wider community of risk inherent in domestic breakdowns does not diminish with the	All professionals and members of the community.	Improved awareness of domestic abuse in older people to be targeted at services who are more likely to work with older people	Southwark Council	Devise and implement elder domestic abuse awareness for older person services	Nov 2019	

age of the partners, the length of the relationship or the lack of reported abuse		Improved awareness of domestic abuse in older people to be targeted at health professionals	Southwark CCG	Devise and implement elder domestic abuse awareness for health professionals in areas such as arthritis, COPD and memory clinics		11/12/2019- 'How Are Things at Home?' Domestic Abuse event held by KCH Nov 2019. GP Protected Learning Event in Nov 2019 specifically focussed on domestic abuse affecting older adults in case study presentations.
		Targeted publicity to be developed and distributed to services / spaces which are more likely to work with older people	Southwark Community Safety Team	Publicity campaign rolled out		Summer 2020- publicity campaign during COVID lockdown included targeting supported living accommodation as well as pharmacies, GP surgeries, shops and parks. Further publicity campaigns are planned.

		Ensure that older people are represented in any engagement process to implement the new Gender Based Violence strategy and domestic abuse service recommissioning	Southwark Community Safety Team	Incorporate elder sector engagement in the new VAWG Strategy and domestic abuse service recommissioning		Older people focus groups scheduled post Covid pandemic to inform future commissioning for DA services and SSAB plan 2020-21 VAWG strategy 2019-2024 updated November 2019
		Southwark Safeguarding Adults Board to revise and update its website to reflect the learning from this review	SSAB team	Website updated		11/12/2019- Wording on website reflects that DA can affect all ages. Information re. DA in older people and links to relevant Solace page included.