DOMESTIC HOMICIDE REVIEW C9

ARISING FROM THE DEATH OF

VICTIM M - DECEMBER 2015

SAFER DEVON PARTNERSHIP

ON BEHALF OF TORRIDGE COMMUNITY SAFETY PARTNERSHIP

OVERVIEW REPORT

VERSION 7.0 – FINAL

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INTRODUCTION TO THE REPORT

PURPOSE

1. This report of a domestic homicide review examines agency responses and support given to Victim M, a resident of Torridge District, prior to the point of her death on [redacted]. The Review Panel offers condolences to her son, niece and all her friends and family.

2. The Review was undertaken by the Safer Devon Partnership on behalf of Torridge Community Safety Partnership. Victim M was killed by her long-term partner Mr T in their home in Torridge (House A). She was then aged 83 and he was 73. Both were of White British ethnicity. Mr T was convicted of murder and sentenced to life imprisonment with a tariff of 20 years on 23rd June 2016.

3. The review considers agencies' involvement with Victim M and Mr T from 2008 to 2015. The start date reflects the point at which Mr T's mental health treatment passed from Devon Partnership Trust back to primary care. In addition to agency involvement, the review examines 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.

4. The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order 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 in order to reduce the risk of such tragedies happening in the future.

5. The report is in five parts: Introduction, Approach, What Happened, Analysis and Conclusions. The Introduction explains the purpose and scope of the review. The Approach section describes how the review was conducted and what sources of information were used. The What Happened section outlines what is known of the background to and the events of the homicide. It then gives a factual account of the involvement of relevant agencies with Victim M or Mr T between 2008 and 2015. The Analysis section draws on this to answer key questions identified in the terms of reference. The Conclusions section sets out the Panel's view on whether agencies acted appropriately, and draws out lessons for the future, including good practice. It makes high level recommendations which are expanded in a separate Action Plan.

DISSEMINATION

6. As a draft, this version of the Overview Report is for distribution only as indicated on the front sheet and covering message. The final version will be disseminated to multi-agency partnerships responsible for reducing domestic abuse, individual agencies and the victim's family described in Appendix A.

TIMESCALES

7. This review began on 22nd September 2016, reflecting agreement with the police not to run in parallel with the criminal trial. National guidance says that the overview report should be completed, where possible, within six months of the commencement of the review. This has not been possible in this case due to difficulty in obtaining access to the medical records of the victim. These had been archived to Primary Care Support England, which took 6 months to release them following a request

by NEW Devon Clinical Commissioning Group. The draft report was sent to the Home Office for quality assurance on 4th December 2017, and their response (Appendix G) returned on 31st May 2018. The Panel regrets the length of time it has taken to conclude this Review.

CONFIDENTIALITY

8. The findings of each review are confidential. Information is available only to participating professionals and their line managers. Pseudonyms are used in this report, as agreed with the family, to protect the identity of the people involved.

TERMS OF REFERENCE

9. The agreed terms of reference reflect Home Office guidance on domestic homicide reviews[1] and set the purposes of the review as to:
   a) Invite the involvement of the family and, as appropriate, friends, to provide a robust analysis of events.
   b) Seek to establish whether there was any agency contact with Victim M or Mr T, which is relevant to identifying any record of domestic abuse or indications that Victim M was at risk of violence.
   c) Consider whether, under the circumstances, agency intervention could have prevented the victim's death.
   d) Provide a report which summarises the chronology of events, analyses and comments on the actions of the agencies involved, and makes any required recommendations for improving the way agencies, singly and together, respond to domestic abuse.
   e) Identify how and within what timescales any recommendations will be acted on, and what is expected to change as a result.

10. The Panel agreed, in the light of the initial information available, that the review should focus on the following questions:
    a) Was Victim M subject to domestic abuse by Mr T prior to the homicide?
    b) If so, did she seek or receive any support from agencies in addressing this, and was the response appropriate to the situation?
    c) Did any agency during 2015 have information about Victim M or Mr T that should, under protocols then applying, have triggered further assessment, intervention or signposting of advice that could have protected her?
    d) Did the fact that Victim M and Mr T were registered at different GP practices[2] hinder the potential contribution of primary care to preventing this tragedy? If so, what barriers did this introduce, and are changes needed to remove them?
    e) Are there lessons from this case about how to help older people in Devon to recognise domestic abuse and seek or signpost appropriate support?

11. In setting these terms of reference, and examining the evidence, the Panel considered the nine protected characteristics under the Equality Act 2010. The age of the couple is taken into account. While neither was registered disabled, both were experiencing some age-related health problems, and this is considered. While they had chosen not to marry, they were in a long-term partnership. The review did not identify any points at which this affected the services available to them.

[1] At the point the domestic homicide review started.
[2] Once under way, the Review found that this was not the case: they were at different branches of the same practice.

APPROACH

DECISION TO UNDERTAKE A REVIEW

12. In Devon a multi-agency Executive Group accountable to Safer Devon Partnership oversees the response to deaths potentially requiring a domestic homicide review under section 9 of the Domestic Violence, Crime and Victims Act (2004). Through a locally agreed protocol the Community Safety Partnerships in Devon meet the requirements of the Act through Safer Devon Partnership. Membership of the Executive Group is listed in Appendix A.

13. Devon & Cornwall Police referred the death of Victim M to Safer Devon Partnership as a potential domestic homicide on 5th January 2016. In line with the protocol, the Domestic Homicide Review Co-ordinator for Safer Devon Partnership then asked agencies to check records of their contacts with Victim M and Mr T. In the light of a summary of information compiled, the Executive Group agreed at their meeting in May 2016 to initiate a domestic homicide review, and appointed [redacted] as Independent Chair. The Executive Group took this decision because the perpetrator was the long-term partner of the victim, so this was a domestic homicide under the terms of the Domestic Violence, Crime and Victims Act (2004).

EVIDENCE CONSIDERED

14. Most of the public and voluntary sector agencies[3] contacted reported no relevant contact with either of the couple. The only agencies with relevant contact were within the NHS. The following agencies provided detailed information for the Review, such as a chronology or case notes. Those shown in bold were also asked to prepare an Internal Management Review, which is an internal report whose author was not involved in the events. Further information about the Internal Management Reviews received is given in Appendix B.
    - Devon Partnership NHS Trust
    - Northern Devon Healthcare NHS Trust
    - South Western Ambulance Service Trust.

15. Additional sources of evidence were obtained as follows.
    - The NEW Devon Clinical Commissioning Group representative on the Panel obtained the views of Mr T's General Practitioner through telephone and correspondence (with Mr T's consent). Regrettably, attempts to consult another branch of the same practice about Victim M were unsuccessful.
    - The insights of people who had known Victim M and Mr T were sought as discussed below.
    - Devon and Cornwall Police provided a summary of statements made by Mr T after his arrest, and information about details of household arrangements relevant to the terms of reference. The Independent Chair also met members of the investigation team.
    - Mr T agreed to be interviewed, in prison, by the Independent Chair and Domestic Homicide Review Co-ordinator. This took place in February 2017.
    - The transcript of the judge's remarks on sentencing was obtained.
    - Torridge District Council provided a summary of the sources of advice on domestic abuse available to residents of Town F in 2015, and of publicity channels used then and since to raise awareness, particularly those likely to reach older people.

[3] In addition to domestic abuse agencies operating in the area, the offices of Citizens Advice Bureau and Age Concern nearest to Town F were asked. None had any recorded contact.

INVOLVEMENT OF FAMILY, FRIENDS AND WIDER SUPPORT NETWORKS

16. Safer Devon Partnership recognises that the quality and accuracy of domestic homicide reviews can be significantly enhanced by family, friends and wider community involvement, and that families should be given the opportunity to be integral to reviews. Such participation is voluntary for those involved, and Safer Devon Partnership seeks to provide appropriate support and a choice of means of contact.

17. Accounts from the family and friends of Victim M have been an important source of evidence for the panel. In consultation with the police Family Liaison Officer, Victim M's son (by her first marriage) Mr L, and her niece, Ms J, were invited to contribute to the review, as were three of Victim M's local friends. Where references are made to the views of family and friends in this report they draw from these sources, but do not claim to be the views of all members of the family or friends of the victim. Further details of how people who knew Victim M or Mr T were involved are given in Appendix C.

REVIEW PANEL

18. The Panel members at the conclusion of the Review were as shown in Table 1. (Due to internal staffing changes, some agencies were represented by other officers earlier in the process.) The Panel held four face to face meetings between 22nd Sept 2016 and final date, and conferred by electronic means to clarify evidence and finalise details of the report.

TABLE 1: MEMBERSHIP OF THE REVIEW PANEL

Agency	Panel member(s)	Role
n/a	[redacted]	Independent Chair
Devon and Cornwall Police	[redacted]	Serious Case Review Team
Devon County Council	[redacted]	Commissioning Manager, Public Health Principal Social Worker - Commissioning
NEW Devon Clinical Commissioning Grp	[redacted]	Lead Nurse, Adult Safeguarding
Northern Devon Healthcare NHS Trust	[redacted]	Head of Quality and Safety
Splitz Support Service[4]	[redacted]	Service Manager, Devon
Torridge District Council	[redacted]	Environmental Health and Community Safety Manager

19. No members of the Panel had any prior direct involvement with the events or decisions covered by the review, or management responsibility for any staff whose actions are described. The Review Panel operates collaboratively to reach agreed conclusions. It had administrative support from the Safer Devon Partnership Co-ordinator for domestic homicide reviews. No other reviews have taken place into this death, or are proposed.

20. The Panel's report and recommendations, agreed with the Chairs of Safer Devon Partnership and Torridge Community Safety Partnership, take account of comments from family members and from the Home Office appointed national Quality Assurance Panel for domestic homicide reviews. (See Appendices C and G).

[4] The main provider of domestic abuse services in Devon at the time of the Review.

21. The Independent Chair, who was also the author of the report, has never been employed by any of the agencies concerned with this review, and has no personal connection to any of the people involved in the case. Further details of her relevant experience are given in Appendix D.

EQUALITY AND DIVERSITY

22. The Panel has considered the relevance of the nine protected characteristics under the Equality Act 2010 in setting the terms of reference and conducting the review. Noting that both Victim M and Mr T were aged over 70, and had some health and mobility problems, the report comments on whether that may have had an impact on their access to or experience of services.

WHAT HAPPENED

THE HOMICIDE

23. At 4am on [redacted] 2015 Mr T phoned police to say he had assaulted Victim M. Police and ambulance attended and found her dead in the bedroom of House A, their joint home in a residential area of Town F. This was a twin bedroom shared with Mr T.

24. Victim M was found dead on the bedroom floor from blunt force injuries to her head, received from multiple blows in a violent attack, which had started while she was in bed. The judge in sentencing Mr T said: "You struck her with the hammer on her head. Remarkably, she resisted and fought you. In the ensuing fight you struck her several times with the hammer. You caused dreadful injuries to her head. There is no doubt that you intended to kill her, because you told the police that you had to make sure she was dead. She died as a result of her dreadful injuries."

25. The instrument was a lump hammer, which Mr T said he kept in his study (next to the bedroom) as a deterrent against burglars. (No evidence emerged as to whether Victim M was aware of its existence. Mr T used this room as his private space, and she had the third bedroom as hers.) Given his age and health, he must have made a sustained effort to complete the killing. Following the murder, Mr T took prescription Diazepam tablets and turned on the gas cooker hob, filling the house with natural gas, in what he said was a suicide attempt. About an hour later, having changed his clothes, he called the police.

26. Mr T gave no clear reason for his actions during the criminal investigation or since, and there is no direct evidence as to what triggered the attack. Forensic tests found no recent alcohol use. The judge in sentencing accepted there was no premeditation "in the sense that there was no planning, but you did leave your bedroom to get the murder weapon". He was often awake and active during the night, so may have disturbed Victim M, in their small twin bedroom, and taken her response as a reason. What she said cannot be known, but the review draws together indications of her likely state of mind prior to the attack.

27. There were no other members of the household. Mr T had no children. Victim M had an adult son by her first marriage, Mr L, who lived on his own in village G, about 17 miles from Town F. She was also close to her niece, Ms J, who lived on the Isle of Wight but kept in touch by telephone. Victim M had been living with Mr T for around 40 years, initially in south east England and at House A since 1999.

28. Mr T was charged with murder and was found guilty at the Crown Court.

BACKGROUND (TO 2008)

29. Victim M was born in 1932 and brought up in Sussex by an aunt following the death of her mother when she was 4 years old. She was at school during the war, then had a career in the Post Office, initially as a telephonist and, after an interval bringing up her son, in systems design. Friends and family saw her as an intelligent, thoughtful, woman who had not had the opportunity to study beyond the school leaving age; a talented artist and good at relating to people.

30. Victim M married Mr N, her first husband, when she was about 22. Until that point she had lived with relatives, helping care for Ms J who was 12 years younger than her. She and Mr N had one child, Mr L. The marriage ended in divorce around 1970, when their son was in his mid teens and chose to stay living with his father. There is no indication that any domestic abuse occurred in this marriage. Soon after, Victim M married again. Family say her second husband, Mr O, was aggressive and an alcoholic. The marriage did not last long, ending in divorce. Mr L, then in his late teens, recalls his mother asking him to retrieve her possessions by stealth after she left the home. She did not report this domestic abuse to the police.

31. It was soon after this, around 1975, that Victim M and Mr T met, when they rented flats in the same house in south east England. Mr T had not previously married. He had had a girlfriend some years earlier, and admitted to feeling jealousy in that relationship, but not while with Victim M. At this point he was in his early 30s and she in her early 40s. They soon set up home together, initially renting and then buying. They never married. Family describe Victim M as revering Mr T's cleverness. Mr T described their relationship as a love that had grown over time and plateaued, but denied that the relationship had broken down.

32. Victim M and Mr T shared some interests, including photography, walking and theatre, and took holidays abroad together. Victim M later described this stage of her life to friends in positive terms. However, family were aware of some holidays that had gone wrong after odd behaviour by Mr T – for example disappearing for a few days. The couple are not known to have taken holidays together since retiring to Devon, but until recent years Victim M took holidays without him, for example trips with the older people's social group University of the Third Age (U3A). She visited her family on the Isle of Wight about three times a year, often with her son.

33. Mr T was highly educated as a scientist and reached a senior research post in a major pharmaceutical company, based in the south east. He left work in the late 1990s, taking early retirement during a reorganisation. Victim M, who was 10 years older, had already retired at this point. He was a reclusive character outside work. He undertook most of the maintenance of their house himself, and family see this as linked to his desire for privacy.

34. The couple then moved to Devon in the late 1990s, choosing town F as within reach of Mr L, who had moved to the south west some years before. They owned their home, House A, as tenants in common, with no mortgage. It is a detached house in a residential street, with a number of steps down from the street to the front door, and overlooking woodland at the back which was part of the property. It had an attractive garden which Victim M enjoyed looking after. The couple operated a joint account for household expenses, but had individual bank accounts for pensions and savings. They both had good occupational pensions, and Victim M had some capital inherited from her brother.

35. Mr T had had a long medical history of mental health problems, including several admissions to psychiatric hospitals / units when younger, and took medication for these problems for many years. He was sectioned under the Mental Health Act during his student years as a result of misuse of

prescription medication. Family say that at the time Victim M met him he was an alcoholic, and she went with him to Alcoholics Anonymous meetings.

36. He was treated as an outpatient by Devon Partnership Trust between 1999 and 2008. In summary, this was a history of ruminating depression and suicidal ideation, and an obsessive personality. Victim M told relatives he was suffering from manic depression. In January 2008 Mr T was discharged back to the care of his GP, with no further contacts with the Trust.

37. Victim M had no history of mental health problems. The following points from her medical history prior to 2008 are potentially relevant:
    - In 2005 she had a total hip replacement at Northern Devon Healthcare NHS Trust .
    - In December 2005 she had a routine colonoscopy, due to family history of colorectal cancer. Symptoms abated and the record notes she put them down to a bit of irritable bowel syndrome caused by stress.

RELEVANT CONTACT WITH AGENCIES SINCE 2008

38. As might be expected given their age, both parties had a number of contacts with healthcare services during the period covered by this review. However, neither made any calls to the NHS 111 information service. The contacts with Northern Devon Healthcare NHS Trust and South Western Ambulance Service Trust are listed in Appendix E, and in summary are:
    - For Victim M, planned hand surgery in 2010, a fall in 2011, another in 2012, two falls and further hand treatment in 2013;
    - For Mr T, arm injury and shoulder surgery in 2013, wrist injury in 2014, four attendances at emergency units in 2015, two with signs of alcohol misuse.

39. Mr T's treatment for mental health issues continued in primary care, with the same GP seeing him 3 or 4 times a year. He had been prescribed Diazepam for many years, sometimes with other medication. (In a letter to Northern Devon Healthcare NHS Trust prior to a planned operation Mr T himself explained this as "… prescribed... as a counter to my undefined and frequent anxiety states".) The GP reported that at no time did he express, nor did the GP suspect in him, a risk of violence to others. Mr T did on occasion disclose thoughts of deliberate self-harm to himself only, but never any firm plans, intentions or decisions.

40. Victim M told friends and family that Mr T thought, due to his professional background, that he understood his medication better than doctors, and sometimes chose to increase the dosage, resorting to over the counter pain killers or alcohol when his prescription then ran out early. He does not appear to have disclosed this to his GP. Victim M's family recall her saying she had told her own GP of her concerns about it and asked them to tell his GP. Mr T's GP has confirmed that no such message was received and that he had no direct contact with Victim M.

41. The nature of Mr T's mental illness at the time of the homicide was an issue in the trial. The prosecution case that it was mild and chronic. The defence case suggested a short-term escalation leading to diminished responsibility. The jury accepted the prosecution case. The judge in his sentencing remarks said "The jury's verdict means that your mental illness of a chronic depressive disorder did not substantially affect your ability to think rationally or to exercise self-control. In those circumstances your culpability can have been lowered by no more than a minimal amount."

42. The Review has not been able to obtain information directly from Victim M's GP about primary health care she received, or any concerns she shared about Mr T. Individual GP practices are not among the agencies cited in the law relating domestic homicide reviews, although NHS England, which now

commissions them, and Home Office Guidance, stress the importance of their involvement. Primary Care Trusts, which were named in the legislation, no longer exist, and there is a frustrating lack of clarity about which, if any, of their successor bodies has taken on this duty in Devon, and so can ensure lessons about the role of GPs in preventing domestic abuse are learned.

43. Attempts by the NEW Devon Clinical Commissioning Group panel member to facilitate voluntary participation by the GP practice were unsuccessful. However, information on Victim M's health can be inferred from other sources including hospital notes. She was in reasonable health for her age, but suffered balance problems from a chronic condition and so used a stick. There is no indication from other sources that she contacted the GP in the days before the homicide.

44. The only other non-routine contact with public agencies during this period was a written enquiry by Mr T to Torridge District Council in July 2013 about whether planning permission was needed to repair a wall.

45. Neither Victim M nor Mr T made contact with any of the voluntary agencies providing support on domestic abuse. Nor did they contact agencies (such as Devon County Council's Care Direct, Citizens Advice or Age Concern) providing advice for older people.

EVENTS SINCE 2008 NOT INVOLVING AGENCY CONTACT

PATTERN OF LIFE FOR VICTIM M

46. In her time in Devon Victim M made a number of friends and became involved in a range of local activities including the U3A, art classes, a pensioners' club and Pilates. She was also a keen gardener, for which the grounds of House A gave good scope. She was described by friends as warm, sensible, caring and having a real interest in people. She visited her son Mr L regularly, making him meals and helping in his garden. She also kept in touch with friends elsewhere, for example driving to meet a friend in Somerset.

47. Throughout this period Victim M's friends and relatives rarely saw her at home, or met Mr T. She and they preferred to meet elsewhere, due to her uncertainty about his mood and behaviour. While they saw her as someone who did not want to burden others with her problems, she did confide some concerns about Mr T's difficult behaviour, but maintained some privacy. She did not give any indication, even when asked directly, that she had experienced or feared any physical violence.

48. Victim M had her own car and continued driving until the end of her life. However (unsurprisingly given her age and the hazards of rural roads) she became less confident in driving long distances or in poor weather, and looked to her son or friends to transport her on longer trips.

49. She had her own mobile phone (not a smartphone) but preferred to use a landline, choosing times when Mr T would not overhear. She did not have access to the internet. Relatives had offered to buy her a tablet for Christmas in 2015, but Mr T told her it would not work in their home. This was true up to a point: there was no Wi-Fi service in the house, but he had ordered a router for delivery at the end of the year.

50. Victim M continued, as throughout their relationship, to take responsibility for household tasks including shopping, cleaning and laundry. Mr T did not enable Victim M to order delivery of food or other household supplies, leaving her to buy these at stores and carry them down the steps to the house. They prepared and ate meals separately due to his unusual eating habits.

51. Victim M had control of her own finances, with a reasonable occupational pension. In addition Mr T made a regular monthly payment of £100 into her account. Family and friends saw her as good at handling money – for example switching bank accounts and planning pension investments - and free to make her own spending decisions.

PATTERN OF LIFE FOR MR T

52. Mr T had no friends retained from his working life or made on moving to Devon, and accepts that he could be seen as a recluse. After the death of his mother, who is said by family to have been dominant and jealous, he had no close relatives living in Britain. He is not known to have joined any local organisations. He was courteous to Victim M's friends and relatives on the rare occasions when he met them, except when he had been drinking. By 2015 contacts with neighbours had become acrimonious, including a dispute over erection of a shed on a boundary. His anger was not, however, expressed through physical aggression.

53. Mr T was a frequent computer user, albeit staying with dial up access to the internet. Police examination of his computer found no evidence of links to sites promoting violence or suicide. He took part in online betting on sports. He had his own car, which he used for local travel, and a mobile phone which he rarely used.

54. He was a very private person, not wanting strangers in the home. This extended beyond rejecting Victim M's suggestions of engaging a decorator or window cleaner, to refusing to have the boiler serviced. He undertook DIY work on the property when fit enough.

55. For much of the time Mr T lived in Devon he continued alcohol misuse, although through drinking large quantities of beer rather than spirits as earlier in his life. He sought to conceal this by buying cans at a variety of different shops, and disposing of empties secretly. However, he managed to reduce his dependency, partly as a response to having an injured shoulder, and states that for the four years before the homicide he very rarely used alcohol (although admitting to the occasions on which health staff had noted it).

56. Mr T had an unusual pattern of spending his time, often going to bed for days or weeks at a time, and also being awake and sometimes active in the middle of the night. He had obsessive eating habits, repeating the same meal every day for months at a time.

57. Mr T's obsessive personality was apparent to friends and family, directly or via Victim M. He could become fixated on a problem to the point where it consumed all this thinking, and small issues were magnified. An example shortly before the homicide was his worry over choosing a new computer. His query to Torridge District Council on a planning matter in 2013 illustrated his capacity to give disproportionate effort and attention to a minor issue.

NATURE OF RELATIONSHIP

58. Family members had witnessed past arguments between the couple in which Mr T, through a combination of assumed intellectual superiority and his obsession with detail, sometimes exacerbated by drink, spoke to Victim M in a controlling manner. This was to put her ideas and opinions down, rather than dictate her actions. She tolerated this up to a point, but would then argue back. Friends describe her as feisty and strong minded.

59. The activities that Mr T and Victim M had enjoyed doing together withered during their early years in Devon, and by 2015 little was left except television watching and crosswords. He had lost interest in

life generally, including her activities and friends. They did continue to care about each other, and friends observed her putting a lot of effort into trying to look after him. Mr T describes the relationship as at a low ebb, but not broken.

60. Victim M found Mr T's moods and behaviour a constraint on her ability to continue the activities she enjoyed outside the home, compounding the limitations she faced through increasing age. While he did not overtly prevent her going out, he made his displeasure clear, so that she worried as to what she would find on her return. Friends admired her for keeping her spirits up in the face of this.

61. By 2015 Victim M no longer felt able to leave Mr T overnight except for visits to her family. He felt that she valued them more than him, and did not appreciate what - in his view - he had done for her. He admits pleading with her not to go to the Isle of Wight in December 2015. However, he said he did like her to be happy, realised he could not supply this, and recognised after her return that this trip had made her happy.

62. Victim M's friends and family think that she would have disclosed physical violence if it had occurred before the homicide. Ms J recalls asking her, during 2015, whether there had been violence and Victim M saying "no, nothing like that" but that Mr T was increasingly being "nasty" or "vile" in what he said to her, using his verbal skill to hurt her, including comments on her family. She did not disclose the content of this.

63. Family and friends saw Victim M as wanting the situation to change, but not contemplating leaving Mr T. They ascribe this to a mix of her history of seeing him as cleverer than her, her very limited experience of living alone, her loyalty and concern for him, and her recognition that moving out would be complicated. At least two people had offered her a temporary home with them.

DEVELOPMENTS IN DECEMBER 2015

64. As detailed in Appendix E, the final three weeks before the homicide saw:
    a) Mr T having a fall, under the influence of alcohol, which could be interpreted as a deliberate or unconscious attempt to prevent Victim M from going to visit her niece.
    b) Victim M, very distressed by this, and saying "I can't cope with this anymore", persuaded by Ms J to make the trip anyhow, and driven there by her son Mr L.
    c) Victim M relaxed and cheerful during the three night holiday, but not wanting to talk about her home situation.
    d) Mr T, after her return home, phoning his GP to discuss continuing pain following his fall, revealing anxiety about his health but nothing else untoward.
    e) Victim M going out to planned visits to family and friends just prior to Christmas, mentioning Mr T fussing about his health, but not indicating any marked change in his behaviour.
    f) Victim M making a long phone call to Ms J on Christmas Eve, in which they discussed finance and housing as detailed below. (Mr T is unlikely to have overheard this, but it is impossible to be sure.)
    g) Mr L visiting Victim M at home on Boxing Day, while Mr T (unusually for the festival) remained in bed.
    h) Victim M's last contact was a friendly greeting to a neighbour while putting out bins on 29th December, a few hours before the homicide.
    i) Mr T said he did not leave the house between his return from hospital and the homicide.

65. During the call to her niece on 24th December, Victim M shared her concerns about future housing and finances. She said that Mr T had told her that if he had another fall he would go into a care home and this would take all his money and all of hers. She asked for advice of future housing options,

wondering if they would be able to buy a bungalow or warden assisted flat. Ms J talked through some options for moving both with and without Mr T and looked up some property values. She told her aunt to go and get some advice from Citizens Advice or Age UK after Christmas, and checked that she had a local friend to confide in. By the end of the conversation Victim M was much more upbeat.

66. Mr T was aware that Victim M wanted to move to somewhere more suitable to their state of health, and was himself worried about the steep steps at House A. They had discussed this in 2014. He agreed that a move to a bungalow on a flat site would be desirable, but argued that, despite each having some capital savings, they could not afford it.

67. Victim M had also recently discussed with two friends Mr T's comments that she would not be able to afford to stay on in House A without his income. She had told them that she thought she probably could.

OVERVIEW

68. In summary, as 2015 drew to a close, Victim M while in reasonable health for her age, found herself in an unacknowledged caring role for Mr T, who had increasingly withdrawn into their home, and was demanding more of her attention. Their jointly owned home was no longer a safe environment for either due to their history of falls and lack of level access from the road, and Mr T's refusal to engage external help with maintenance. He was unwilling to contemplate moving, and, incorrectly, told her that she would lose her home and income if he needed residential care, thus putting pressure on her to stay in and ensure his safety. She had friends and relatives she could confide in, and her own transport, phone and income, but was finding it harder to use these freedoms due to his obstructive behaviour and her increasing frailty.

69. Encouraged by family and friends, she had, following her usual December trip to visit family without him, come to the point where she was intending to seek advice, probably from Citizens Advice about housing and care finance, and perhaps look at alternative properties for both of them locally, or for herself in the Isle of Wight where relatives would be close by. She was not seeking advice on domestic abuse, as she, like many of her generation, would have seen that as meaning physical violence. She had not yet initiated any external contact, and was probably waiting until after the New Year holiday.

70. The couple had had no contact with police or social care. Mr T had recognised mental health problems for which he had received treatment for much of his life, in recent years via a GP he saw regularly. There was no indication that these had worsened. He had in the past been an alcoholic, concealing his drinking. He had regained control of his intake to a large extent but did binge drink on supermarket beer on occasions in 2015.

71. Both Mr T and Victim M had received treatment for falls from South Western Ambulance Service Trust and Northern Devon Healthcare NHS Trust on several occasions over the previous 3 years. These did not result in serious injuries and there is no reason to think they arose from violence. In Mr T's case, the alcohol misuse was noted as a likely cause.

ANALYSIS

NATURE OF RELATIONSHIP

72. While Victim M maintained contact with friends and relations during 2015, this was through meeting them away from her home or via phone calls, so they did not see Mr T or the couple together. In the

health service contacts at this time, the focus was on whichever of them was the patient, with little direct observation of their relationship. Hence, in considering Victim M's relationship with Mr T in the final year of her life, the review has drawn mainly on what she told friends and family. They recognise that she put boundaries on what she chose to share.

73. There is no reason to think that Mr T used physical violence, or the threat of it, against Victim M before the homicide. Friends and family are confident that she would have told them of this, and probably reported it to the authorities. She confirmed to her niece that his abuse was verbal rather than physical. He had no record of prior violence in any context.

74. Aspects of Mr T's treatment of Victim M in recent years could be described as domestic abuse, though not meeting the threshold of the criminal offence of coercive control. Through moodiness, asking her to abandon plans, and possibly through precipitating injuries to himself or alienating neighbours, he attempted to reduce the time she spent outside the home and get her to focus on his perceived needs. Looking back, family see a pattern in the timing of his health incidents prior to her planned holidays. He turned away family offers to get her internet access.

75. Other aspects of his behaviour were self-centred, though perhaps not constituting domestic abuse. Although she was 10 years older than him, he expected her to continue doing domestic chores such as carrying heavy shopping, although he could have used his skills to help her, eg through online grocery orders. Although becoming less able himself to undertake maintenance work around the home he refused to allow tradespeople to be called in. Her age, and genuine concern for his welfare, made her increasingly vulnerable to this exploitation.

76. Victim M did not think of this behaviour as domestic abuse. She and her friends would use terms such as "being a pain", "making things difficult", or "selfishness" to describe it. She remained, according to her friends, stoic in accepting her situation, tolerating Mr T's behaviour but still able to stand up to it on occasion. However, the intensity was increasing and she was weary of it.

77. The earlier history of the relationship, as recalled by family and friends, included some of these elements, but not a consistent pattern of abuse. Victim M suffered some adverse impacts of Mr T's mental health problems, for example strange behaviour on holidays. While Mr T was observed using a domineering style of argument with her, this seems related to his obsessive personality rather than deliberate control, and she was able to stand up to him. However, she was said to accept his view of himself as her intellectual superior, which may have affected her confidence in, for example, assessing their finances. Her family found some of her past financial transactions surprising and think may have been made under pressure.

78. While the couple did not marry, they had stayed together for over four decades. This may have been important to Victim M as giving security after the instability of relationships in the first half of her life, starting from the death of her mother in early childhood. Both had grown up in an era where dominant behaviour by men was seen as more normal, and something that women should accept. However, both had atypical families in childhood. In adult life, Victim M had a number of female friends, but Mr T did not make friends or join social groups, regardless of gender. He claimed intellectual rather than male privilege.

79. This history does not explain the homicide. Mr T himself does not offer a plausible explanation, and does not attempt to justify it by any criticism of Victim M, her family or friends, or health services. While Victim M was thinking of contacting advice agencies after the New Year holiday, she would have realised the risk of upsetting Mr T by telling him in advance, and there is no evidence that she did so. She was not someone inclined to speak hastily, so it is unlikely that she would have revealed it

accidentally. However she may, in a moment of frustration, have cried out, as she had to relatives on 10th December "I can't cope with this anymore". Mr T has not disclosed any awareness or suspicion of her intentions, or having overheard any of her conversations with others. There is no means of knowing what passed between them that night or over the previous three days.

80. The judge accepted that the homicide was not pre-planned. Mr T's account at the trial was of Victim M being woken by his movement in the night and a trivial complaint about a duvet. Her family think that had she been awake she could have survived the attack and that it is therefore more likely that it started as she slept. Once the attack started, its brutal continuation is consistent with Mr T's obsessive and self-focused personality, and reluctance to change his intentions. He may also have genuinely wanted to put an end to the pain he was inflicting before attempting to end his own life. However, the trigger remains unknown. Mr T admits leaving the room to fetch the weapon, but there is no reason to doubt his explanation that it had been placed there some time ago as a defence against burglary.

HOSPITAL AND AMBULANCE CONTACTS

81. Over the period considered by the review, each of the couple had a range of attendances at local hospitals, which included out-patient appointments, elective admissions for procedures, emergency admissions, attendances at the emergency department at the Minor Injury Units. Assessments were carried out appropriately at each attendance, with the reason for falls checked, and safeguarding checklists filled in. Mr T's history of anxiety and depression was noted, as was his alcohol use. Some enquiries were made about the home situation. Ambulance clinicians are aware of the signs and risks around domestic abuse and would report as appropriate. There is no reason to think that any of the attendances was precipitated by domestic violence, so in that sense no opportunities to intervene were missed.

82. Victim M had several visits to Town F minor injury unit or North Devon District Hospital during 2013. In two of these presentations Victim M provided an explanation of a fall. There did not seem to be any suspicion or concern that these were caused by a third party. Staff followed good practice and documented the reason for the fall on both occasions. While staff followed policy and documentation relevant on presentation to an emergency department at the time, this did not include the question 'Do you feel safe at home?' which was introduced in April 2014. There is, however, no indication from other sources that these injuries were the result of direct action by Mr T, or that Victim M thought herself at risk in 2013.

83. In January 2012 an Independent Domestic Violence Advocate (IDVA) began working within Northern Devon Healthcare NHS Trust . This is not a requirement for health Trusts but at the time this post was jointly funded by health commissioners and a domestic abuse charity. Initially the IDVA was just providing education/training/awareness to front line staff in the Emergency Department and maternity unit at North Devon District Hospital. The awareness raising of domestic abuse was in the form of drop in/briefing sessions and two hour training sessions. Therefore, even though documentation at the time may have not prompted asking the question about domestic abuse, staff would have received training and been aware of the risk factors and signs of domestic abuse.

84. Mr T had several presentations to Town F Minor Injury Unit and North Devon District Hospital during 2015. These were due to falls and re-occurring problems with a previous shoulder injury for which he had undergone surgery in 2012. There did not appear to be any concerns raised about the presentations themselves. However, on two occasions Mr T stated that he had been drinking due to stress of his partner being away or about to go away. Northern Devon Healthcare NHS Trust employs an Alcohol Liaison specialist who supports patients and clinicians in accessing assistance, using a

scoring system to assess need. Mr T's condition did not reach the threshold for referral to support services.

85. In the financial year 2014-15, as part of South Western Ambulance Service Trust ambulance clinicians' annual mandatory training, the session dedicated to Safeguarding focused on Domestic Abuse. This session included the completion of DASH forms. A stand alone Domestic Abuse Policy was also developed and agreed by the South Western Ambulance Service Trust Safeguarding Operational Group in March 2015.

86. ECA1, who was in the ambulance crew attending Mr T on 9th December, recognised that Victim M was concerned about the potential impact of his hospitalisation on her planned trip with relatives. She made a constructive intervention to mitigate this. The South Western Ambulance Service Trust Internal Management Review writer interviewed ECA1 about whether she regarded the situation she observed as domestic abuse, and has reassured the Panel that this was not the case.

87. ECA1's experience and training within both South Western Ambulance Service Trust, and in a previous role at Northern Devon Healthcare NHS Trust emergency department, mean that she was aware of her responsibilities in recognising and reporting domestic abuse. She had completed the South Western Ambulance Service Trust mandatory workbook which includes a section on safeguarding adults and children and also includes domestic abuse. ECA1 had also received safeguarding training which incorporates domestic abuse, and is delivered by one of the South Western Ambulance Service Trust Named Safeguarding Professionals as part of her initial ECA training.

88. ECA1's recollection of the reassurance she gave Victim M is that it was encouragement to her to continue with the trip, rather than feel obliged to cancel it due to Mr T's health, but that she did not perceive or describe Mr T as manipulating her. However, Victim M's comment during the holiday, recalled by her family, was that ECA1's advice was not to let Mr T manipulate her. This may indicate that she herself suspected him of this, and read more into ECA1's reassurance than was intended.

PRIMARY CARE

89. No reasons for concern about the primary care received by Mr T have arisen. His character and professional background made him an informed but probably difficult patient, who was on medication for long-term mental health problems. The GP did discuss risk of harm with him, but found no signs that he had any intention to harm others.

90. There is no reason to think that Victim M presented any injuries arising from domestic abuse to her GP, who was at another branch of the same practice. However it is likely that the GP would have seen evidence that she found living with him difficult. Family recall her saying that she had spoken about Mr T to her GP asking that his GP be informed of her concerns about his pattern of using and supplementing his medication. However, Mr T's GP did not receive any message by this or other means about her concerns. As they were within a single practice there would have been no barrier to the information being shared.

AVAILABILITY OF ADVICE

91. Some of Victim M's family and friends encouraged her to consider leaving Mr T, not because they considered her in immediate danger, but because they could see that his behaviour was making her unhappy. She had offers from both family and friends of a bed while she made further plans. It is not clear whether she had reached the point of seriously considering this, but she was ready to look,

despite Mr T's objections, at options for leaving House A, which with its steps and large grounds was no longer suitable for either of them.

92. There is no evidence that Victim M had already sought external advice on her options for dealing with her increasingly difficult home situation. This would have been a big step for her, as she was unused to making major decisions separately from Mr T, and was of a generation that values privacy in family matters. However, by the time of the homicide she seems to have reached the point where she was ready to do this. This section therefore considers what forms of public and voluntary sector advice would have been available to her. While her mobility was becoming more limited, Victim M had access to a telephone and car, and made trips to local facilities.

93. There is no indication that Victim M thought of herself as a victim of domestic abuse. If she had, there was advice available to support her in understanding her situation and considering her options, although on the basis of information available prior to the homicide the risk to her would have been judged low. In 2015 (and since) this was provided in the Torridge area through Splitz Support Service, with a single access point helpline. This provides assessment of risk and referral to an outreach service, providing practical support, safety planning and advocacy with other agencies, or if deemed high risk, referral to the Multiagency Risk Assessment Conference (MARAC) and an Independent Domestic Violence Advocate. Support includes helping clients to access advice on housing, finances and legal matters. Leaflets and other awareness raising materials were readily available in public places, including libraries, GP surgeries and hospitals.

94. Some general awareness raising on domestic abuse, including making print materials available to public and community venues, has been undertaken in the area each year through the Community Safety Partnership in co-operation with county wide domestic abuse networks. Themes included Valentine's Day in 2010, controlling behaviour in 2014, and violence against mothers in 2015. Of these, the most likely to relate to Victim M's situation was Home is Where the Hurt Is (2009-11), which used a sampler style poster. The J9 Domestic Abuse Initiative, which started in Cornwall, was also used in Town F. It includes a logo displayed in local businesses such as hairdressers which can provide information or allow a safe phone call to be made.

95. The Devon Sanctuary Scheme "helping victims of domestic abuse to stay in their homes" was launched in 2015 and publicized in the Torridge area. However Victim M, on the basis of her situation prior to the homicide, would not have been eligible for this, nor was she seeking sole occupancy of House A.

96. Had Adult Social Care received an enquiry from Victim M (eg via the Care Direct helpline) they would have adopted an "asset based approach" to assessing her situation. This focuses on the person's strengths and skills, and on how they can work with their social network and community resources to achieve desired outcomes. It is unlikely that Victim M would have been thought to have care and support needs in her own right, so if she had disclosed concerns about her relationship with Mr T she would have been signposted to a specialist advice service such as Splitz or Relate. She could have got information about how to arrange paid-for help in running the house or caring for Mr T, but it seems certain that Mr T would not have accepted such external input.

97. It seems more likely that the type of advice Victim M might have sought in early in 2016, would have been on her options for moving out of House A, either to live independently of Mr T, or with him in somewhere easier to manage. Ms J is confident that her aunt would have visited the local Citizen's Advice Bureau after the holiday season. According to family Mr T had, incorrectly, told her that a new home would not be affordable, and suggested that her share of the house would be taken for his care costs. Relevant advice would have been available through Citizens Advice (on financial aspects), Care

Direct (on care in the home and local authority charges). There was a Torridge District Council office in the neighbourhood, and frontline staff there have received training in recognising and responding to domestic abuse. The Council's housing options service would have provided general advice if she had presented as at risk of becoming homeless due to domestic abuse, but not direct assistance unless she was already receiving support from the police or a service such as Splitz. District Councils in Devon have, from 2015, operated to the Devon Code of Good Practice on Domestic Abuse in recognising dealing with housing need arising from domestic abuse.

98. Taken together, these sources are relevant to the situation of an elderly person ending their relationship, or getting a partner to agree to move to a safer environment, in a way that is safe for both parties. While they have distinct roles, they do seek to co-operate and cross-refer. Local public bodies do work together to promote awareness of the availability of advice. For example, the summer 2014 edition of the council's Torridge Connect magazine contains a brief reference to the new Domestic Violence Support Service, and a longer article on a new social care and health website. However, while Victim M might have seen a print copy of the magazine, she would have been unable to follow either item up as only website links were given, with no phone numbers.

CONCLUSIONS

99. The murder of a friendly, intelligent woman who still had much to live for by the man who had shared her life for 40 years could not have been anticipated. There was some domestic abuse through low level controlling behaviour, increasing in recent years as the couple became less mobile, but no previous violence or identifiable trigger for it. Victim M and those who cared about her recognised the difficulties Mr T's behaviour caused her, but they did not think of the situation as domestic abuse. She was starting to consider her future options, but he is unlikely to have known this. Nothing in the couple's contacts with health services for their respective physical ailments indicated that she might be at risk. However, the growing misery of both with their life together was not perceived.

100. Lessons can be learned from this tragedy about recognising the prevalence of domestic abuse among older people, the language they use to describe it, the relevance of health services as points of contact, and the difficulties for older victims in ending a harmful relationship.

LESSONS TO BE LEARNT

RECOGNISING THE RISK OF DOMESTIC ABUSE AMONG OLDER PEOPLE

101. Although Victim M did not regard herself as a victim of domestic abuse, and Mr T's behaviour prior to the homicide did not reach the threshold of a criminal offence, it is likely that a domestic abuse advisor could have helped her reflect on her situation and plan a safe way forward. Services were available which she could have accessed, but their relevance was not recognised by a generation accustomed to thinking of domestic violence as "battered wives".

102. The prevalence and under-reporting of domestic violence and abuse among older people is starting to be recognised nationally. Appendix F gives some of the national figures found in recent research, which concluded that victims aged over 60 are hugely underrepresented in domestic abuse services.

103. Appendix F also presents some county wide figures from Splitz. As should be expected from the population demographic, more of the victims referred to them were over 60 than the national average, but at 7% this is well below the 39% of the adult population who are over 60. This

information was presented to the Splitz stakeholder conference in June 2017, which drew multi-agency attendance, contributing to the sharing of learning from this Review.

104. Devon County Council is planning to undertake further research into the nature of domestic abuse among older residents, and the appropriate service response. Learning from Victim M's tragic death, and those of other older victims, will help inform this.

IMPORTANCE OF HEALTH SERVICES AS POINTS OF CONTACT WITH OLDER PEOPLE

105. Victim M and Mr T, like many Devon residents aged over 70, had several contacts with health services each year. People over 65 account for over 40% of hospital admissions nationally. Both primary and secondary care provide an opportunity to invite older people to recognise and seek help with domestic abuse in a setting that may be more acceptable to them than involving the police or approaching a specialist service.

106. Health services in Devon have continued to improve the processes and training they use to enable front line staff to recognise and respond to domestic abuse. Both Northern Devon Healthcare NHS Trust and South Western Ambulance Service Trust have appropriate arrangements for training staff and enabling them to report concerns. Relevant patients presenting to the Emergency Department and MIUs are now asked whether they feel safe at home. This review has, however, highlighted the challenges of identification of subtle safeguarding signs especially with the elderly group.

107. Since April 2014 the documentation completed at Northern Devon Healthcare NHS Trust accident and emergency department and minor injury units includes the question "Do you feel safe at home?" The Trust currently has an up to date domestic abuse policy, and has an IDVA who is supervised by the named nurse for safeguarding children. Northern Devon Healthcare NHS Trust is in the process of implementing an electronic health record, moving away from paper based notes. This will allow more automated flagging when an individual presents at an emergency department or MIU on a frequent basis, allowing further enquiry if appropriate.

108. In South Western Ambulance Service Trust, safeguarding referrals can be made from the electronic tablet that the clinicians use to complete the clinical record. This also includes the DASH form in electronic format. There were 2109 safeguarding referrals in Devon by South Western Ambulance Service Trust in 2016, an increase of over 50% since 2014. Of these, 157 related to domestic abuse - more than double the 72 in 2014. When the Safeguarding Team receive a referral that relates to domestic abuse involving an adult it is sent to the GP, and to adult social care if the person is over 65 years of age or meets the criteria under the Care Act 2014. The Police are also informed (unless already attending the incident) if a crime has been committed.

109. The Safeguarding section of the annual mandatory training for South Western Ambulance Service Trust clinicians in 2017 focuses on 'Back to Basics' and includes emphasis on controlling and coercive behaviour. The Named Safeguarding Professional East undertakes the Safeguarding Training for the Clinical Hubs including NHS111, although South Western Ambulance Service Trust no longer has the contract for NHS111 Devon. This training looks at how to spot possible domestic abuse from a call taker's point of view and how their concerns should be dealt with.

SAFELY ENDING ABUSIVE RELATIONSHIPS IN OLD AGE

110. Victim M faced a worsening situation at home, as Mr T's behaviour became more demanding and both of them became frailer in health. In planning her future, and deciding whether to leave him, she faced challenges which are less common for younger women, including the prospect of living alone

for almost the first time in over 80 years. Their situation illustrates some of the ways in which older people may find it particularly hard to end abusive relationships. Appendix F shows that people over 60 who do contact domestic abuse services are far more likely than those under 60 to still be living with the perpetrator.

111. Victim M had the benefit of friends and family who had offered a temporary accommodation had she chosen to move out, and might have advised her on how to find a new home. Without some advice she would have found it very challenging. She had no experience of using the internet. It was many decades since she had chosen property or engaged a solicitor on her own. Although she had her own income and some accessible savings, most of her capital was in the jointly owned House A, and her age might have made it difficult to obtain alternative finance while seeking access to this. In helping older victims of domestic abuse, it is important to recognise the additional limitations they may face in accessing information and finance for housing.

112. Victim M may also have been reluctant to leave Mr T due to concern for his future. She could reasonably have thought he would be unsafe if living alone without some form of additional support or monitoring given his record of falls and lack of other friends and family. However, he would at that point have been judged to have capacity to decide for himself where to live, and whether to seek any care. In helping older victims of domestic abuse, it is important to recognise the validity of concerns they may feel for the perpetrator's welfare.

113. The services offered by Torridge District Council and Devon County Council follow national policy in seeking to help older people in independent living, with a focus on helping them remain in their homes. Future policy on care for frail older people remains a topic of national debate. Among the many factors to be considered in this, it is important to recognise that some of the households involved will be ones where there is unreported domestic abuse, either long-term or arising from the changes old age brings.

RECOMMENDATIONS

114. These recommendations are developed in more detail in the separate action plan and are cross-referenced here to the supporting paragraph in this report.

R1 Promote awareness among older people in Devon of the range of forms domestic abuse can take, and the availability of local advice and support. (#101-#104)

R2 Ensure that domestic abuse training for front line staff recognises the particular risks and challenges for elderly victims. (#106, #111-#113)

APPENDIX A: SAFER DEVON PARTNERSHIP OVERSIGHT OF DOMESTIC HOMICIDE REVIEWS

Safer Devon Partnership provides the strategic leadership for addressing community safety matters across Devon, aiming to work together to enable the people of Devon to feel and be safe in their homes and communities. Partners include the four Community Safety Partnerships in the county, the Police, Fire and Rescue Service, Clinical Commissioning Groups, Public Health, Office of the Police and Crime Commissioner, National Probation Service, the Community Rehabilitation Company and Children's Services (including the Youth Offending Service).

One of Safer Devon Partnership's purposes is to provide (on behalf of the Community Safety Partnerships) the governance for domestic homicide reviews as they are required in the county. Under the protocol agreed, this is delegated to an Executive Group. At the time of this Review the Executive Group was led by the Chair of the Safer Devon Partnership Board, and included representatives of:

- Devon County Council
  - Chief Officer for Communities, Public Health, Environment and Prosperity
  - Elected Member with responsibility for Community Safety
  - Principal Communities and Commissioning Manager (with responsibility for Domestic and Sexual Violence and Abuse)
  - Safer Devon Partnership Manager
  - Principal Social Worker, Adult Social Care
- Devon & Cornwall Police
  - Detective Chief Inspector for Local Investigations (Devon) and SODAIT
  - Detective Sergeant from Serious Case Review Team
- North, East and West Devon Clinical Commissioning Group (NEW Devon CCG)
  - Designated Nurse, Safeguarding Adults

The final version of this Overview report will initially be distributed to:

- Members of Torridge Community Safety Partnership, via its Chair.
- Chief Executive and officer with responsibility for domestic homicide reviews (in this case the Environmental Health and Community Safety Manager) of Torridge District Council
- Members of the Safer Devon Partnership Board
- Safer Devon Partnership's domestic homicide review Executive Group
- Chair of the DSVA Strategy Oversight Group (which has responsibility for the DSVA Strategy and Action Plan and is accountable to the Safer Devon Partnership).
  - Comprised of senior managers, the group is responsible for leading and supporting a coordinated response to DSVA in Devon, through the strategic coordination of commissioning of DSVA services, partnership working and receiving assurances that effective and appropriate organisational responses are in place. Any work, projects or commissioning activity conducted on DSVA will be overseen, agreed and informed by the DSVA Strategy and Delivery Group
- Safer Devon Partnership Manager (who has responsibility for the management and co-ordination of domestic homicide reviews)
- Chair of the Devon Safeguarding Adults Board and the Chair of the Devon Safeguarding Adults Review Group
- Chair of the Devon Children and Families Partnership (Devon's Local Safeguarding Children's Board) and the Chair of its Serious Case Review Subgroup.
- Police and Crime Commissioner for Devon, Cornwall and the Isles of Scilly
- Family as agreed.

- Also, with a view to co-operation, on implementation of relevant recommendations, the Chairs of Plymouth, Cornwall and Torbay Community Safety Partnerships.

APPENDIX B: INDIVIDUAL MANAGEMENT REVIEWS

An Internal Management Review (reported to the agency concerned and the Panel only) is carried out by an agency officer not involved in the case, typically one with a quality assurance role. They review the agency's records and policies, interview staff involved (where appropriate and still contactable) and report on:

- the chronology of relevant interaction with the victim and / or perpetrator;
- what was done or agreed;
- whether internal procedures were followed; and
- conclusions and recommendations from the agency's point of view.

AGENCY	IMR WRITER	INDEPENDENCE	STAFF INTERVIEWED	OTHER SOURCES
SWAST	Named Safeguarding Professional. (Full time role covering Devon, Cornwall & Isles of Scilly. Qualified and experienced paramedic.)	The author has not been involved with either the victim or perpetrator and has no line management responsibility for the clinicians involved within this case.	ECA1	Adastra clinical records.
Northern Devon Healthcare NHS Trust	Safeguarding Adult Lead (postholder to Dec 2016).	The author has not been involved with either the victim or perpetrator and has no line management responsibility for the clinicians involved within this case.	No	Patient records

APPENDIX C: INVOLVEMENT OF FAMILY, FRIENDS AND SUPPORT NETWORKS

Those invited to contribute to the review were given a Home Office leaflet about domestic homicide reviews and a choice of means of contact. The Panel Chair, with the Devon County Council Domestic Homicide Review Co-ordinator, met Mr L and Ms J at their respective homes, and also met three of Victim M's local friends. No-one who was invited to participate declined.

A Victim Support worker, already known to him, was present at the meeting with Mr L, and assurance was obtained that others interviewed had access to people who could support them. Interviews were recorded, by consent.

At the end of September 2017 Mr L and Ms J, together with a more distant relative of Victim M who had supported them at the trial and a Victim Support worker, met the Independent Chair and Domestic Homicide Review Co-ordinator They read through the draft Overview Report, Executive Summary, and Action Plan, asked questions about the process and offered ideas for clarification and improvements. They were offered the opportunity to retain the documents for further discussion but declined. The points raised, including some enhanced detail of past events observed by the family, were addressed in the draft report sent for quality assurance.

APPENDIX D INDEPENDENT CHAIR / REPORT AUTHOR

[redacted] was the Independent Chair of this domestic homicide review, and the report author, steering the work of the Review Panel and drafting this report which reflects their agreed conclusions. Responsibility for the final report and publication following quality assurance by the Home Office rests with Safer Devon Partnership.

[redacted] has undertaken this role for some of the other domestic homicide reviews undertaken by Safer Devon Partnership. Other than this she has no connection with Safer Devon Partnership or Torridge Community Safety Partnership, and has not worked for any of the agencies named in this review.

The main part of her career was with the Audit Commission, an external regulator of public bodies including councils, police forces and NHS Trusts. The role involved evidence based independent reports on these public services, taking account of the views of service users. She had a regional lead role on community safety, and contributed to national reports on drug misuse, mental health and partnership working. Following the reduction in the Audit Commission's remit she left in 2011 and now works freelance.

APPENDIX E: DETAILED CHRONOLOGY OF CONTACT WITH AGENCIES

This chronology covers agency contact with Victim M and Mr T over the period of interest, and includes known contacts with friends and family in the last few weeks of her life. The notes column provides context information, not evaluation.

Date	Agency	Event	Notes
04/10/10	NDHT[5]	Victim M attended day Surgery Unit for planned release of left ring trigger finger	
24/09/11 13:48	SWAST[6]	999 call. Victim M had head wound as a result of a fall in the garden at House A. She lost her balance and struck her head on a plant pot sustaining a minor laceration to the right side of her head. Victim M was up and walking around when the ambulance crew attended and was able to freely recall what had happened. The mechanism of injury was a mechanical fall, following examination the wound was found to be minor, it was dressed and Victim M was conveyed to [Town F] Minor Injury Unit (MIU)	
24/09/11	NDHT	Victim M attended [Town F] Minor Injury Unit due to laceration to right side of head. Explanation: crouching down whilst gardening, lost balance and hit her head on a concrete flowerpot.	
10/06/12 20:50	SWAST	999 call. Arm injury. Mr T fell, possibly on to a dining room chair and then on to the floor at approximately 09.00 hours whilst tidying the downstairs at House A. He was noted to have bruising on his chest from the fall and had difficulty raising his right arm. Following an examination Mr T had pain and swelling to his right arm and was conveyed to North Devon & District Hospital (NDDH) for a further assessment.	A friend of Victim M recalls her having to cancel a much wanted trip to Venice at some point in 2012 due to Mr T having an accident.
10/06/12	NDHT	Mr T attendance at A+E at NDDH - injury to right arm injury. Explanation of injury down to tripping over chair. Accident occurred approx. a week earlier but he hadn't attended hospital earlier due to reported hospital phobia. X rays indicated right humerus fracture.	NDDH is North Devon District Hospital.
27/06/12	NDHT	Mr T planned admission to NDDH for right reverse polarity shoulder replacement. Notes state history of depression and anxiety	
27/08/12 21.18	SWAST	999 call. Victim M slipped on the last step outside of her house (House A), sustaining a possible fracture to her left ankle. The ankle was splinted and Victim M was conveyed to NDDH for further assessment.	
28/08/12	NDHT	Victim M A+E attendance following fall on step outside house in the dark injuring her ankle Patient documentation states anxious re concern for partner who had recently broken shoulder.	
18/06/13	NDHT	Victim M attendance at A+E injury to right wrist following fall	
20/06/13	NDHT	Victim M fracture clinic appointment. Stated fall coming down some steps in her garden (related to above injury). X-ray completed two days previous in A+E revealed fracture to right distil radius. Plaster cast put in place with follow up clinics.	
29/07/13	Torridge District Council	Mr T wrote to ask if a planning application was needed for repair of a wall on the driveway at House A. The planning department replied on 4th Sept to say it was not. Mr T's letter was countersigned by Victim M and refers to him having discussed the matter with her and with various neighbours, who all agree with him on the way forward. There is no indication in it of any strained relationships. The style illustrates Mr T's obsessive personality, with 3 pages of text and 24 photos used to explain his thinking on a minor and uncontroversial issue.	
3/09/13	NDHT	Victim M attendance at [Town F] Minor Injury Unit attendance with head injury following fall.	

[5] Northern Devon NHS Hospitals Trust
[6] South Western Ambulance Services Trust

		Explanation: tripped over stool indoors at home and hit head on wooden table. Lost consciousness.	
28/10/13	NDHT	Victim M [Town F] Minor Injury Unit attendance requiring splint to middle left hand. Mallet injury to finger.	
30/10/13	NDHT	Victim M seen in outpatient clinic following above attendance on 28/10/13. She could not remember any incident but was hanging washing up when she noticed that she was unable to actively extend the end joint of her left middle finger. Mallet splint put in place with follow up clinics.	Mallet finger is an injury to the end of the finger most often caused by a minor injury, eg catching finger on clothing.
31/05/14	NDHT	Mr T attendance at A+E at NDDH - injury to left wrist. Injured on 24/05/15 working on out house, carrying chipboard and tripped over it, put left hand out. Pain to ulna/radius.	
23/03/15	NDHT	Mr T minor injury attendance at Town F community hospital - injury to left foot. Kicked aluminium loft ladder with bare foot.	
26/04/15 13.57	SWAST	999 call. Mr T fell the previous evening in his kitchen; he had no recollection of how or why he fell. He crawled upstairs last night and managed to walk down them today, but is concerned that he has 'broken his right leg and a toe'. Mr T admitted to drinking several cans of high strength beer prior to the arrival of the ambulance crew. Mr T was described as a poor historian and several times he complained of pain in his leg and then stated that it wasn't painful. During the examination there was an abrasion noted over his right eye and it was slightly tender. Due to the fact that Mr T had been drinking and was a poor historian and the evidence of an abrasion, a possible head injury couldn't be excluded so he was conveyed to NDDH.	
26/04/15	NDHT	Mr T attendance at A+E at NDDH – head wound and minor injury. Reported falling previous day, able to mobilise but concerned he has broken his leg and toe. Documentation states partner on holiday for weekend therefore drank 8 cans of 'Stella' yesterday. About 23.00 had fallen in kitchen on floor. Went to bed until 9am and then drank 4 cans of beer to relieve pain. Head injury and soft tissue injury to toes on right foot. Noted history of depression and right shoulder replacement.	
15/6/15	NDHT	Mr T attendance at A+E at NDDH - injury to right shoulder. Worsening right shoulder pain following a fall. Deformity, reduced movement, pain and tender scapular. History of right shoulder hemiarthroplasty.	Shoulder hemiarthroplasty is a partial replacement by a prosthetic metal implant.
27/10/15	Primary Care	Mr T attended the surgery (in Town F) for a routine appointment with his regular GP.	
09/12/15 21.44	SWAST	999 call. Mr T explained that he felt unwell the day before whilst out. He had spent today in bed feeling sick. This afternoon he had been drinking alcohol and was seen to get from a chair, stagger across the room and fall into a glass door, bumping his head. Victim M called 999 as Mr T was unable to get up. After examination the ambulance crew could not find an explanation for this episode of illness but felt that alcohol intoxication the most likely cause. Mr T insisted that the reason was not alcohol related and wanted to be taken to hospital. The ambulance crew felt that leaving him at home was likely to result in another fall so they conveyed him to NDDH.	
9/12/15	Family / SWAST	Victim M later told her family that a female paramedic came back into the house after Mr T was in the ambulance advising Victim M that she should not allow him to manipulate her. This staff member is identified in the SWAST Internal Management Review (IMR) as ECA1, an Emergency Care Assistant who had joined SWAST in February 2015, after 16 years' experience with NDHT as a healthcare assistant (most recently in the Emergency Department). When interviewed for the IMR she had some recollection of the	

		incident and recalls that Victim M was either due to go away with her son or was doing something with her son and because Mr T wanted to attend hospital Victim M felt that this might not happen. ECA1 did not feel there was any issue around domestic abuse and that Victim M was upset about Mr T attending the hospital.	
10/12/15	NDHT	Mr T attendance at A+E at NDDH. Intoxicated possible fall. Rib pain. Noted history of anxiety/black outs. Patient stated had slept for 24hours due to stress over computer problems and had also been drinking alcohol due to stress over partner visiting Isle of Wight this weekend.	
10/12/15 morning	Family	Victim M telephoned Ms J and started crying on the phone. She said she really wanted to come to visit her, but she wasn't sure she would get away. Victim M said "I can't cope with this anymore", referring to Mr T, and recounted the ambulance visit. Ms J reassured her aunt, and then phoned Mr L to confirm he would pick her up early the following morning.	
11/12/15	Family	Mr L collected Victim M from House A at 7am to take her to visit Ms J and other relatives on the Isle of Wight. On arrival she was elated and relaxed for the whole visit.	
14/12/15	Family	Mr L returned Victim M from the Isle of Wight to House A.	
17/12/15 13:02	Primary Care	Mr T organised telephone consultation as he was still suffering chest wall pains following a "? intoxicated - Fall - Home with verbal advice" presentation at local A&E Dept." The doctor he spoke to was not the GP he usually saw. There was no mention of Victim M specifically, though the GP did note "follow up with Usual Doctor as has other issues to discuss". The notes also recorded "stressed this morning with pleuritic chest pains following a fall 8 days ago" and "sounded well if anxious" re his mental health at that time.	The reference is to the incident on 9/10 Dec.
23/12/15	Family	Victim M met a woman friend for lunch at a garden centre about 10 miles from her home, driving herself there. She told the friend that Mr T was still in bed. She said she and Mr L had been away to visit her niece but she didn't think she would be able to do it again as she never knew what she would find at home on her return. The friend took this to mean Mr T and his behaviour. After lunch she bought some paracetamol, with the friend's help to get 4 packets (rather than the limit of 2 at the supermarket), saying Mr T would double up on the dosage so would run out in half the proposed time and she did not want to have to shop again over Christmas.	
24/12/15	Family	Victim M visited her son Mr L, who recalls that she seemed quite happy, and mentioned the lunch with a friend the previous day. She also said that Mr T had been "playing up" either that day or the previous day trying to get her to get the doctor out to him.	
24/12/15 4.30pm	Family	Victim M phoned Ms J and "seemed OK". She said that Mr T had told her that if he had another fall he would go into a care home and take all his money and all of hers. Then she asked what she could do in the future; and they had a long talk about this. Victim M asked her niece if she would be able to buy another house or would they be able to buy a bungalow or a warden assisted flat. Ms J talked through some options for moving both with and without Mr T and looked up some property values. Ms J told her aunt to go and get some advice from Citizens Advice or Age UK after Christmas, and checked that she had a local friend to confide in. By the end of the conversation Victim M was much more upbeat.	
26/12/15 6-9pm	Family	Mr L visited his mother at House A, chatting and watching television. Mr T was upstairs in bed. Victim M told her son he claimed to be ill but she thought he was too embarrassed to see him. Mr L interpreted this as embarrassment about the events on 10-12 Dec.	On previous Christmas visits by Mr L, Mr T was present for part of the time.
29/12/15	n/a	Victim M greeted a neighbour while putting rubbish out for collection.	From police interviews.
[redacted]	Police	999 call from Mr T reporting that he had killed Victim M.	

APPENDIX F: CONTEXT INFORMATION ON DOMESTIC ABUSE AMONG OLDER PEOPLE

National and Local Research on Older People

"Safe Later Lives: Older People and Domestic Abuse" (SafeLives: October 2016), is a report produced as part of the Spotlight series on hidden victims on the national picture. The report makes the following national estimate of the scale of the problem.

What do we know about older victims of domestic abuse?

Although there is no widely accepted prevalence data for this age group, we estimate that in the last year approximately 120,000 individuals aged 65+ have experienced at least one form of abuse (psychological, physical, sexual or financial). Although Marac (Multi-Agency Risk Assessment Conferences) data does not include this age bracket, figures show that only 3% of victims aged 60 or over are accessing ***Idva*** *services supported by the Marac model.*

Profile of clients	***60 and under***	***Over 60***
Perpetrator is current partner	*28%*	*40%*
Male clients	*4%*	*21%*
Adult family member is the primary perpetrator	*6%*	*44%*
Multiple perpetrators	*9%*	*7%*
Attempted to leave the perpetrator	*68%*	*27%*
Average length of abuse	*4 years*	*6.5 years*
Physical health & mental health	*6 & 7*	*6 & 6*
Physical abuse	*69%*	*69%*
Sexual abuse	*25%*	*10%*
Harassment and stalking	*73%*	*57%*
Jealous and controlling behaviours	*83%*	*73%*

On average, older victims experience abuse for twice as long before seeking help as those aged under 61 and nearly half have a disability. Yet older clients are hugely underrepresented among domestic abuse services.

Splitz Support Service Statistics 2016/17 (Devon)

7% of victims referred were over 60, compared to the national dataset (SafeLives Insights) figure of 4%.
18% of victims over 60 were male, compared to 6% of all victims referred (includes 60+).
38% of victims over 60 declared a disability, compared to 17% of all victims.
59 % of victims over 60 reported abuse to the police, compared to 64% of all victims.
Average length of time of abuse 10 years, compared to 4 years for all victims.
62% of perpetrators of abuse to over 60s did not have a criminal record, compared to 22% of perpetrators of all victims.
43% of over 60s were still living with the perpetrator, compared to 12% of all victims.

APPENDIX G: HOME OFFICE QUALITY ASSURANCE COMMENTS

Home Office

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Julie Richards
Safer Devon Partnership Manager
Communities Team
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County Hall
Topsham Road
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31 May 2018

Dear Ms Richards,

Thank you for submitting the Domestic Homicide Review (DHR) report for Devon (C9) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21 March 2018. I apologise for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a well written, thorough report which carefully explores and clearly articulates coercive controlling behaviour amongst the older generation. The Panel noted the accounts provided by family and friends were integral to the review and give important insight into the relationship of the couple, including their lifestyles. The Panel commended the chair of the review for also making enquiries with the local Citizens Advice Bureaux and Age Concern. The Panel found the referencing of research on older people in Appendix F especially helpful.

There were some aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- You may wish to consider some form of expression of condolence which is normally included within DHR reports;
- Pseudonyms rather than the initials would allow a reader to more easily follow the narrative and make it more personal;
- The Panel suggested that a representative from Age UK would have been beneficial to this review;

- The executive summary should contain the full terms of reference and the names and job titles of review panel members so that the report can be read in isolation;

- Consider removing the precise date of death to enhance anonymity;

- The Panel felt the review could further explore the concept of male privilege which was a dominant feature in this couple's relationship;

- The framing and narrative in paragraphs 77 and 78 should be reviewed as the Panel felt the assumptions presented were not sufficiently evidenced.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Hannah Buckley
Acting Chair of the Home Office DHR Quality Assurance Panel