Domestic Homicide Review

Overview Report

Safer North Hampshire Community Safety Partnership

Report into the murder of Alice (Adult F)

May 2014

Author – Shonagh Dillon (3rd Author)

December 2018

Glossary

AAFDA – Advocacy after Fatal Domestic Abuse

CA – Citizens Advice

CCB – Coercive and controlling behaviour

CCG – Clinical Commissioning Group

CPS – Crown Prosecution Service

CPR - Cardiopulmonary Resuscitation

CSP – Community Safety Partnership

DASH – Domestic abuse Stalking and harassment (risk assessment0

DVA – Domestic Violence and Abuse

DHR – Domestic Homicide Review

ED – Emergency Department

GP – General Practitioner

IMR – Independent Management Review

JTAI – Joint Targeted Area Inspections

SECAmb – South East Coast Ambulance Service

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DHR Overview Report into the Murder of Alice, May 2014

Preface

The third independent author, DHR panel and Safer North Hampshire Community Safety Partnership wish to offer their deepest condolences to everyone who was affected by Alice's[1] death.

1. Introduction and Background

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011.They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself; with a view to identifying the lessons to be learnt from the death[2].

1.2 The purpose of a DHR is to:

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

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

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

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

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice

[1] Not her real name

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office - December 2016

1.3 This report of a domestic homicide review examines agency involvement and responses afforded Alice, a resident of Hart in Hampshire prior to her death in May of 2014. The review will consider agency contact with her and the perpetrator, David[3], her son, from May 1st 2012 – May 31st 2014. This time frame was agreed to be appropriate by all original panel members in July 2014.

The decision to undertake a DHR was made by Safer Hart Community Safety Partnership (CSP) in May 2014 and the Home Office was subsequently informed. The CSP commissioned the first independent author of this report to commence the review in July 2014 and there were a total of three meetings held. These were:

- 24th July 2014
- 26th September 2014
- 16th June 2015

The relationship between the first chair/author and the CSP broke down in 2015.

The DHR Panel became frustrated by the apparent lack of coordination in relation to the DHR and inconsistencies within the first draft report. Despite detailed amendments being put forward by the Panel the second draft contained many of the same inconsistencies as the first.

Following further discussions between the nominated provider and the Joint Chief Executive of Hart District Council it was decided to sever the arrangement.[4] During the period of the initial DHR, talks were ongoing with the Police and Crime Commissioner with regular updates, amendments and discussions at CSP level with regards to moving from a collaborative working arrangement to a formally merged CSP. This merged CSP (Safer North Hampshire) would cover three areas previously known as Safer Hart, Safer Basingstoke and Deane and Safer Rushmoor.

Following the breakdown of relationship with the nominated provider, the report was then reassigned to Caroline Ryan, Community Safety Manager, Safer North Hampshire. Once the report had been rewritten it was circulated to the original DHR panel for comment and amendment, and following approval was submitted to the Home Office in April 2017 following a short delay due to unforeseen circumstances and a period of absence.

An email was received from the Home Office outlining a backlog of work and anticipating a delay in the review of the DHR. The Home Office panel subsequently sent back their recommendations on the report in October 2017. The Home Office letter is listed under appendix A in this report.

[3] Not his real name

[4] This section of the report is written by the CSP Manager with consent of the panel members

Following concerns about the impartiality of the Safer North Hampshire Community Safety Manager with regard to writing the report, the decision was made to commission a third author to the report, Shonagh Dillon (Chief Executive, Aurora New Dawn), on October 4th 2018.

1.4 The third executive summary and Overview report were presented to the Safer North Hampshire Domestic Homicide Panel on15/05/19 They were submitted to the Home Office on 07/06/19 and were considered at the 23/10/19 meeting of the Home Office Quality Assurance Panel. The Home Office provided notification and approval for publication on the 22/11/19.

The Safer North Community Safety Partnership (CSP) is a strategic partnership made up of Statutory Agencies who oversee the work of Community Safety Partners over the Safer North Hampshire area.

Safer North Hampshire takes instances of domestic abuse very seriously and coordinates the work of the North East Hants Domestic Abuse Forum and local agencies in order to improve the safety and wellbeing of all those affected by domestic abuse across North Hampshire[5].

The North East Hants Domestic Abuse Forum was founded in the mid 1990's and its membership is made up of representatives from the many local agencies that work with the victims of domestic violence and abuse who live and work in Basingstoke and Deane, Hart and Rushmoor.

The forum aims to promote multi-agency working, collective decision-making, and comprehensive information sharing and data collection. Through these mediums it will be able to spearhead initiatives, disseminate information and signpost agencies that provide support and assistance. Most importantly the forum wishes to work towards improving the health, well-being and lives of the many victims of domestic violence/abuse, whoever they may be.

It is noteworthy that at a time where many domestic abuse forums have been unable to continue, due to restraints in resourcing, the North East Hants Domestic Abuse Forum is still a vibrant and well attended meeting, with many multi agency partnerships feeding into the knowledge and expertise provided by the forum.

The overall strategic guidance in Hampshire for domestic abuse is provided by the Hampshire Domestic Abuse Strategy 2017 - 2022[6]. In relation to this review it is of value that the strategy makes reference to "knowledge gaps for older people" (p.9).

[5] Safer North Hampshire - https://www.safernh.co.uk/about/community-safety-partnership/
[6] Hampshire Domestic Abuse Strategy 2017 – 2022 - http://www.hampshiresafeguardingchildrenboard.org.uk/wp-content/uploads/2017/11/HampshireDomesticAbuseStrategy.pdf

1.5 Persons Involved in the DHR

Name	Sex	Age at time of Murder	Relationship with victim	Ethnicity
Alice	Female	79	Victim	White UK
David	Male	58 (at time of the incident)	Son and Perpetrator	White UK
Lucy	Female	Unknown	Daughter in law	White UK
Mark	Male	Unknown	Son	White UK

Alice had one other adult son. David had no children and no partner at the time of Alice's murder.

Originally, in the first author's draft report, Alice was referred to as AK and David BK. Subsequently the second chair and author referred to Alice as AF and David as BF. The third author has taken the guidance given by the Home Office and has given the names identified in order to humanise the review process and ease the reading of the report.

1.6 Summary of the Case

Alice was a 79 year old retired divorcee when she died. She was living in a privately-owned house in Hart, Hampshire. Alice had two sons, one of which lived with her and had done so for approximately 20 years. Alice's ex-husband had been deceased for many years and there is no history of domestic abuse relevant to this case.

David was 58 years old at the time of this incident and working part time as an exercise instructor locally.

There is limited information on Alice's contact with others in the lead up to her death, although we do know from witness statements that Alice had few friends and little social life. It is known that she was last seen by someone other than David, two days prior to her death. This individual has been identified as an elderly friend of Alice who declined involvement in this review process.

Alice last spoke to her second son Mark[7] two days before her death when she told him that she was upset following an argument with David over use of the telephone.

[7] Not his real name

On the morning of the murder, David was booked to teach a Pilates class at a local health club at 10.30 am. David telephoned the club stating that he would not be attending as he had 'something to sort out'. He was seen walking his dog between 10.30 and 10.45 am by the local postman. At 10.44 am police received a call from Lucy[8], Mark's wife, stating that David had called her and disclosed that he had 'strangled mother', and David had asked if Mark and Lucy would take care of his dog.

Police arrived at the home address of Alice and David at 10.55 am and found a set of keys outside the front door. On entry to the property, police found Alice laying on the floor; she was pale and had no detectable pulse. The Ambulance service were called and the attending officer began CPR.

At this point, David returned to the property and was arrested on suspicion of attempted murder.

Paramedics attended the house and took Alice to Frimley Park Hospital where continued efforts were made to save her life. Alice did not regain consciousness and was later pronounced dead.

A Home Office Pathologist later examined Alice and found her to have died from brain injury caused by pressure to her neck. There were no other injuries reported.

David was subsequently charged with the murder of Alice and remanded in custody.

2. Parallel Reviews and processes

2.1 A Home Office post mortem was conducted in June 2014 where Alice was found to have injuries to her neck and symptomatic petechial haemorrhage to the eyes consistent with manual strangulation.

2.2 David subsequently appeared before Winchester Crown court in October of 2014 and pleaded guilty to murder. He was sentenced to life imprisonment with a minimum sentence of 12 years to be served.

2.4 There were no other parallel review processes arising from Alice's death.

3. Domestic Homicide Review Panel

The DHR panel consisted of the following agencies:

Job Title	Agency
Community Safety Manager	Safer North Hampshire (2nd Author)
Head of Serious Case Reviews	Hampshire Constabulary
Head of Safeguarding	Hampshire County Council – Adult Services

[8] Not her real name

Joint Chief Executive and Chair of Hart Community Safety Partnership (at time of incident)	Hart District Council
Portfolio Holder for Community Safety (at the time of the incident)	Hart District Council
Chair	North East Hampshire Domestic Abuse Forum
Partnerships Manager	North East Hampshire and Farnham Clinical Commissioning Group
Consultant Nurse	North East Hampshire and Farnham Clinical Commissioning Group
Partnerships Manager	Purple Futures Community Rehabilitation Company
Community Safety Officer	Safer North Hampshire
Coordinator	The Hartley Wintney Voluntary Care Group and Hartley Wintney and District over 55s Forum

4. Independence

4.1 The author of this report, Shonagh Dillon, was independent of all agencies involved in the panel having been commissioned sometime after the initial panel meetings she had no dealings with the initial inquiries and no contact or knowledge of the family members. She is also independent of the two previous author's and chairs and did not sit on the panel.

Shonagh Dillon is a Home Office accredited DHR chair and has over two decades in the violence against women sector supporting victims and survivors of domestic abuse, sexual violence and stalking.

4.2 Additionally, all IMR authors and Panel members were independent of any direct contact with the subjects of this DHR. None were the immediate line managers of anyone who had had direct contact.

5. Terms of Reference

5.1 The full terms of reference, which were agreed at the first panel meeting are included in Appendix A of this report.

5.2 The specific areas of consideration were identified as follows:

1) Clearly defined purpose of the DHR
2) Agreed Membership for the DHR Panel
3) Collation of evidence from all agencies

4) Analysis of findings
5) Liaison with the victims' family
6) Development of a report
7) If relevant, the development of an action plan
8) Sign off by the CSP DHR Panel
9) Submission to Home Office

The overarching premises of the review were:

- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

- The review looked at the involvement of any statutory and voluntary sector agencies with Alice and David from 1st May 2012 to 31st May 2014. The timeframe was agreed by the panel in 2014 to be an appropriate window to perform analysis on the review.

6. Confidentiality and Dissemination

6.1 Whilst it has been essential to share key issues with agencies and organisations involved in this DHR, this report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

The IMRs will not be published but this DHR report will be made public.

The content of this DHR report is anonymised in order to protect the identity of the victim, perpetrator, family, friends, staff and others to comply with the Data Protection Act 1998.

6.2 Once clearance has been given by the Home Office quality assurance group the dissemination of the overview report will be published on the Safer North Hampshire and Hart District Council websites and be widely disseminated including, but not limited to:

- Members of the Safer North Hampshire Community Safety Partnership
- The Hampshire Safeguarding adults board for dissemination in their own partnerships
- The Hampshire Domestic Abuse Partnership

6.3 The North East Hants DVA forum will take the lead on ensuring the recommendations and action plan are carried forward.

7. Methodology

7.1 Following the decision to conduct this DHR, agencies were requested to return Summaries of Involvement to help the panel understand what, if any, contact agencies had with Alice and David during the specified period of review.

Having considered the Summaries of Involvement, it was decided to request the following Individual Management Review (IMRs):

a. Frimley Park NHS Hospital Foundation Trust
b. North East Hampshire and Farnham Clinical Commissioning Group on behalf of Primary Care.

The authors of the IMRs are independent in accordance with the guidance.

7.2 The third author was given all the information available. This included minutes of the panel meetings with the first commissioned independent author and chair, the IMR's, the second author's report and the recommendations from the Home Office Quality Assurance Panel, as show in Appendix A.

Subsequently the third author analysed the information available and further requested a full transcript of the police investigation interview with David and any other witness statements.

7.3 This report is based on:

- The findings of the IMRs
- The perpetrator and witness police interview and statements
- Information from David's employer

This report's conclusions and recommendations are the collective views of the Panel, which has the responsibility, through the participating agencies, for implementation of any improvement recommendations.

8. Involvement of Family and Friends

8.1 Initial contact with the family was made through the Police Family Liaison Officer and the family declined contact with any of the agencies represented. Subsequent letters were sent to the family, enclosing the Home Office leaflet on DHRs but to date, no response has been forthcoming and it must therefore be considered that they have chosen not to participate in this process.

8.2 Further enquiries were made with the police case officers to establish if Alice had any other family and/or friends who might consider engaging with this process. Only one individual, an elderly lady who was a close friend of Alice and who saw her two days before her death, was considered for contact.

8.3 A letter was sent to the home address of this individual but no response was received.

8.4 A subsequent attempt was made to contact this individual at which point she declined involvement[9]

8.5 The third author, Shonagh Dillon, gained all information available and considerable thought was given to the proposal of contacting the family and Alice's friend again for the purposes of this stage of the report writing. Advice was sought from Advocacy after Fatal Domestic Abuse (AAFDA), to consider the impact this may have on Alice's loved ones, particularly after such a considerable time since her death.

8.6 Ultimately the decision was left with the author of this report. It was felt that having read the witness statement and victim impact statement from Mark, Alice's only other son, and his explanation of the obvious ripple effect this had caused his immediate family coupled with this report being compiled four and half years after the murder; the emotional impact of contacting Alice's loved one's at this time would be too great and may cause them unnecessary emotional pain.

However, the third author did manage to arrange a meeting with David's main employer and colleagues, their responses are considered in the analysis of this report.

Alice

8.7 Given the understandable decision for family and friends not to be involved in the DHR we know very little about Alice. However, victims' voice is so often lost in the process of a review and it is important they do not get forgotten in the machinery of bureaucracy.

The little bits of information we do have about Alice from witness statements can give us some indication of who she was as a person. Alice loved to garden, she spent hours cultivating her plants and took great pride in them, she adored her dog and would walk him daily. She also had a passion for wildlife. Alice had five siblings and four weeks prior to her death one of her sisters had passed away

Although this only gives us a very small picture of who Alice was as a person it is important that her presence is not lost to us in this process.

The Perpetrator

8.8 David was a single man residing in a bungalow that he jointly owned and occupied with his mother, Alice. He was a self-employed Pilates and yoga instructor who worked 12 hours per week at leisure facilities close to his home address.

8.9 David told police that he had no friends, that it was just him, his dog and his mum. David further stated that in the weeks leading to his mother's death, they had

[9] 8.1 – 8.4 information quoted directly from the second author report

had limited social interaction, each choosing to speak to the dog but not to each other.

8.10 There is no record of David having any previous dealings with the police, probation service, Adult Social Care or substance misuse services prior to his arrest for the murder.

8.11 There is no evidence that David had any issues with alcohol or substance misuse and he was not found to be under the influence of alcohol or drugs at the time of his arrest.

8.12 Arrangements were made to visit David in prison but he refused to leave his cellblock on the day. The value of the DHR process was made clear to David by his offender manager but again he refused to engage.

8.13 During interview David told police that he believed himself to have undiagnosed mental health issues.

8.14 It was established that David had not spoken to his GP about his mental health since the 1980s. David stated that there had been a bad atmosphere at home for a few weeks and that on the morning of the incident he had 'flipped', grabbing his mother by the neck and squeezing.

8.15 David stated that he and his mother had argued previously but violence had never been used before. David felt that his mother was critical of him, putting him down in company and overlooking his achievements.

8.16 David did not have any financial pressures, however, it did concern him that during the day his mother would use the house phone to make calls rather than making them from her mobile telephone at no charge.

8.17 David stated that his mother had been housebound since a fall in November 2013, however, Alice had been seen out in the Town Centre after this date.[10]

8.18 In his interview with police, David referred to his relationship with his Mother as being like "an old married couple". When quizzed further by police about any disagreements he might have had with Alice, he also stated that he felt it would have been good to have "marriage counselling."

8.19 David stated that the issue with the use of the mobile phone, which Alice found difficult to use, was the catalyst for him strangling her. He stated that Alice had called him "stingy" for insisting on her using the mobile phone, instead of the landline, to save money.

8.20 In interview David insisted that his Mother was acting unreasonably because of the issue with the mobile phones, which led them to not speaking to each other for approximately two weeks before the murder. When asked whether the death of her sister may have caused Alice to be responding unreasonably to situations like the mobile phone David refused to concede that Alice may have been grieving.

[10] 8.9 – 8.18 information quoted directly from the second author report

8.21 In interview David states that after Alice had difficulties using the phone whilst trying to get hold of another sibling after their sister's death, an argument ensued. In this argument David states that he told her a few "home truths" about how Alice always belittled him and in the argument David states Alice suggested that he should leave and they should sell the house.

8.22 In interview David makes reference on two separate occasions to having "explosive" episodes. He states that these were not "violent" only "verbal". David made reference to having issues at work and sending an email to his boss because he felt he wasn't running the business properly. David states he "stored things up for years and years and years" and that he felt "entitled" to send the email, but that this had "cost him" because he had to "leave work for…two months almost."

Verifying evidence

The reference to Alice and David being like an "old married couple" was also mentioned by Mark, Alice's other son.

Reference to the argument about the use of mobile phones was also noted by Mark

David's Employer

8.23 The author of this report took the opportunity to contact the main employer of David to see if they would be willing to add their thoughts as part of the review process

8.24 Initially the author arranged to meet just the manager of the fitness centre, however, other colleagues of David were keen to add their thoughts to the review. In total four of David's colleagues, including the manager, spoke to the author of this report. The summary of these conversations is detailed below:

The manager:

The Manager of the fitness centre had known David for approximately four years.

He stated that he had received an email from David quite out of the blue one day after a blanket email sent to all staff with some relevant management instructions. David had written an email back that seemed to be entirely disproportionate to the situation and this had surprised the manager a lot at the time. David subsequently resigned as soon as the email was sent and the manager made every effort to resolve the situation but David was unrelenting and chose to leave. Sometime later David wanted to come back to work at the fitness club so a meeting was arranged between HR and both David and the manager and he was given some of his classes back.

The manager was happy to show the author the email exchange and having viewed all the emails the author confirmed that the reaction was both aggressive and disproportionate to the situation.

Generally the manager had very little to do with David and he explained that they merely exchanged civil words to each other. The manager felt that he tried to engage David in conversation but that David "did not like him" and they avoided each other.

The manager also stated that although he and David were not friends, he was a very popular teacher and his classes were well attended, there had been no issues with him at work prior to this email. David was also well liked by staff and was more amenable with them.

Other Colleagues:

The other colleagues the author interviewed all spoke of their shock and surprise at what David had done to his Mother.

Some of the salient quotes in description of David were:

- "He was very private, kept himself to himself"
- "He was kind and very attentive as an instructor"
- "He was really quiet he never made much conversation"

Given that David had worked with many of his colleagues for nearly 20 years none of them had ever met Alice and they said he never spoke of Alice. Sometimes she would call the centre but she never chatted to them.

David's direct line manager and another colleague did note that his behaviour and demeanour did change in the months leading up to the murder. One noted that he was "short tempered" and the other mentioned that they noticed he was "less tolerant".

His supervisor mentioned that she felt he was "unusually private about his home life."

9. Independent Management Reviews and other information[11]

Mental Health

9.1 Alice was not known to the Mental Health Trust and had not reported any concerns to her GP during the review period.

9.2 David had reported some mental health concerns to his GP in the 1980s. Despite attempts to gain permission to access David's medical records for the purpose of this review, David failed to respond and this has to be considered a refusal.

9.3 David gave consent for the police to access his medical records and as part of the judicial process was seen by a psychiatrist. When sentencing, His Honour Judge Cutler stated 'it is the view of the psychiatrist that interviewed you, that you have no mental illnesses'.

Individual Management Review – FRIMLEY PARK NHS TRUST

9.4 Records held by the Trust in relation to Alice reveal that she attended the hospital a number of times prior to 2011. These attendances were for general medical complaints and no concerns regarding possible domestic abuse were raised at any of these attendances.

[11] Information in section 11 quoted directly from the second author report

9.5 The Trust has no record of Alice's family beyond that fact that she lived with her son in Hart. It was noted by the IMR author that during a hospital admission in 2008, (for two days)[12] nursing staff made note of the fact that Alice was not visited by David.

Individual Management Review – GP

9.6 This DHR process revealed that the only point of contact between Alice and any statutory body over the two years prior to her death was with her GP.

9.7 Historical records revealed that Alice was divorced at the beginning of the 1980s. There is no record of any domestic abuse being identified.

9.8 In the two years prior to Alice's death there were eighteen recorded contacts. These contacts included telephone advice and visits to the surgery. Alice was known to have a history of hypothyroidism and hypertension. These conditions were managed through regularly prescribed drugs and monitoring by the doctor. Alice also reported a number of incidents of chronic pain. There were no incidents, injuries or concerns recorded that would give rise to suspicion that Alice was victim of any form of domestic abuse.

9.9 On attendance at the surgery on January 22nd, 2014 relating to an episode of acute bronchitis, Alice mentioned to the doctor that she had fainted in November 2013. Alice related the fainting episode to newly prescribed medication and voiced concerns about being unsteady on her feet. The doctor recorded that Alice was able to walk her dog around a local pond for an hour with the aid of a stick. The reason that Alice did not seek medical advice at the time of the faint was not recorded.

9.10 In April 2014, Alice made her last visit to her doctor prior to her death. Alice was complaining of neuralgia to the left side of her face which she claimed to have been experiencing for the past 4 years. Nothing abnormal was detected on examination and appropriate medication was prescribed.

9.11 The first IMR author spoke to the victim's GP who is also the safeguarding lead for the practice. It was noted that all practice staff had received safeguarding adults training and that this training included domestic abuse. The practice has a 'flagging' system for recording situations where there was a history of domestic abuse. On examination of Alice's records, no issues were identified that would have required inter-agency communication.

9.12 It is noted that the local Domestic Abuse Forum have provided many local surgeries with DV training over and above mandatory safeguarding training and regularly provide up to date literature for display in waiting areas.[13]

Agency Information Checks – Hart District Council

9.13 Records held by the Local Authority were checked for information on both the victim and the perpetrator. Records revealed that Alice and David moved to their

[12] This information was added by the third author

[13] A request from the third author was made for more information on the role of the forum and their work in relation to this case – this information is provided in section 14.

property as owner-occupiers in July 2012. No further information of note was held and the authority was not required to conduct an IMR.

10. Analysis

Although there is little to no information from statutory agencies in respect of Alice or David there is some analysis that can be completed from the information laid out in the report thus far.

Coercive Control

10.1 Coercive control legislation came into effect in the UK on 29th December 2015. Although Coercive control was not in force when Alice was murdered it is important to analyse it as a potential factor in the relationship between Alice and David.

"The cross-Government definition of domestic violence and abuse outlines controlling or coercive behaviour as follows:

- *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: a continuing 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.*

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence in their own right. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- *isolating a person from their friends and family;*
- *depriving them of their basic needs;*
- *monitoring their time;*
- *monitoring a person via online communication tools or using spyware;*
- *taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;*
- *depriving them of access to support services, such as specialist support or medical services;*
- *repeatedly putting them down such as telling them they are worthless;*
- *enforcing rules and activity which humiliate, degrade or dehumanise the victim;*
- *forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;*

- *financial abuse including control of finances, such as only allowing a person a punitive allowance;*
- *threats to hurt or kill;*
- *threats to a child;*
- *threats to reveal or publish private information (e.g. threatening to 'out' someone).*
- *assault;*
- *criminal damage (such as destruction of household goods);*
- *rape;*
- *preventing a person from having access to transport or from working."*[14]

(This is not an exhaustive list)

Living as a married couple

10.2 Both David, and his Brother Mark, described Alice and David's relationship as being one that was akin to an old married couple. David goes further in his police interview to suggest that they may have needed "relationship counselling." Whilst nothing can be inferred from this other than their long standing living arrangements, the context in which the murder occurred may give us some possible indicators of coercive control and escalation.

10.3 The situation David describes in his interview with police and subsequently confirmed by Mark his brother was that Alice and David had argued about Alice's use of the landline phone. David wanted Alice to use a mobile phone rather than the landline to call her family and friends and Alice, by all accounts, found the use of a mobile difficult. Given Alice's age and her obvious isolation it is unsurprising that using the mobile would have been something alien to her. She may also have felt that this was a prescriptive measure given that we know she contributed to half of all the bills in the house and paid her way in equal measure to David financially.

10.4 Although there is no evidence of financial control from David from the information made available to the author, it is noteworthy that David felt the need to control Alice's use of contact with the outside world by prescribing to her that she use the mobile instead of the landline.

10.5 From the information available we know that Alice and David argued about this factor and this resulted in Alice not wanting to speak on the phone to anyone and hanging up on people who did call her. Being unable to speak to any of her friends or other family members we do not know Alice's feelings around this, but it can be inferred that this left Alice further isolated from contact with the outside world and cut off from communicating in a way she was comfortable with.

[14] Controlling or Coercive behaviour in an intimate or family relationship – Statutory Guidance Framework – Home Office December 2015 p. 3-4
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

10.6 Isolation is a common factor used by perpetrators in domestic abuse relationships. It is apparent that Alice lived a solitary life and although she did regularly see one friend at least once a week we also know that her contact with others was via her use of the landline.

10.7 Given Alice's age in relation to her lack of familiarity with technology it would be entirely appropriate for David to concede that using a mobile phone was proving difficult for her and that this was cutting her off from contact with people she cared about, particularly at a time that she was grieving for her sister. It is therefore fair and proportionate to assert that David's behaviour and his insistence that Alice use a mobile was unreasonable. Whether this constitutes a pattern of coercion remains unknown but it is certainly evidence of controlling behaviour.

Escalation

10.8 To reiterate there were no prior incidents of domestic abuse between Alice and David, reported to the police or any other statutory agencies. We also know that Alice was never asked by professionals she had contact with whether she was experiencing domestic abuse. Therefore we have no tangible evidence of any abuse occurring.

10.9 It is, however, notable that in the weeks leading up to Alice's death she had expressed a desire to separate from David and end their long standing living arrangements by selling the home so they could go their separate ways.

10.10 Separation is a high risk factor as noted on the Domestic Abuse Stalking and Harassment and Honour based violence (DASH) 2009[15]. We also know that 75% of women who are murdered in a domestic abuse context, are killed at point of separation or after they have just left[16].

10.11 However, the only information we have available to us is from David's work colleagues, some of whom suggested that his behaviour was different in the months leading up to the murder. Although one of his colleagues did explain this may have been attributed to him having a recent hip operation and therefore he had to deal with a lifestyle change. David had not talked about Alice to his colleagues or mentioned any difficulties at home.

10.12 The lack of evidence means we cannot assume this was a case of escalation in a domestic abuse context, but it is worth analysis. The context in which Alice was murdered, strangulation, is the most likely way a woman will be killed in a domestic abuse homicide[17]. This, coupled with Alice wanting to end the living arrangements

[15] DASH (2009) Laura Richards, https://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/DASH-2009-2016-with-quick-reference-guidance.pdf
[16] https://www.theguardian.com/money/us-money-blog/2014/oct/20/domestic-private-violence-women-men-abuse-hbo-ray-rice
[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4202982/

with David, could point to escalation. The absence of evidence of previous physical injury does not equate to an absence of risk in a domestic homicide[18].

10.13 The only evidence we have for the murder is that of David's investigation interview. In which he would lead us to believe that this occurred simply as an obscure act, a one off, a situation where he "snapped" and strangled Alice. David's explanation is unusual in the context of women being murdered by a family member[19]. Nonetheless, it is the only explanation available.

Routine Enquiry (Health)

10.14 Without the information from other agencies to point us to other abusive behaviours we cannot assume domestic abuse was occurring in the family home. The agency Alice had the most contact with was her GP's surgery of whom she had visited eighteen times in the two years prior to her death. Given Alice's age and various ailments this was not an unusually high number of visits to the GP. 'There were no previous reports or concerns of domestic abuse noted by any agency involved in the review. There were no incidents to elicit analysis of contact, communication or inter-agency procedures'.'[20]

10.15 Health based routine enquiry or "Asking the Question" of a patient and whether they have experienced domestic abuse, has been researched in detail for over a decade[21]. There are many benefits to ensuring health professionals are trained to ask patients whether they are experiencing domestic abuse and in particular this is important for GP practices due to 41% of victims attending general practices for support[22].

10.16 Alice had good contact with her GP's surgery. She showed no signs of experiencing domestic abuse and therefore was not asked the question. However, research shows us that the routine nature of regularly asking every patient the question in health based settings evidences better results. Routinely asking gives the message to victims and survivors that disclosing domestic abuse is acceptable and that everyone is asked therefore nobody is particularly targeted[23].

10.17 It cannot be assumed that Alice would have made a positive disclosure and, as stated, we have no other evidence of domestic abuse. But the nature of routine enquiry fosters a sense of openness about domestic abuse in a general practice and gives those who are experiencing the opportunity to disclose should they need to.

[18] https://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/One_Page_High_Risk_Factor_Definitons_for_Domestic_.pdf
[19] https://www.theguardian.com/society/2015/feb/08/killing-of-women-by-men-record-database-femicide
[20] Information quoted from author two report
[21] http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/rk6280finalreport.pdf
[22] http://irisi.org/
[23] http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/rk6280finalreport.pdf p.8

Older People and Domestic Abuse

10.18 At the time the panel convened there was less information available about older people and DA. The national charity SafeLives have recently put a "spotlight" on Elder Abuse and highlighted the need for us to respond to older people in a different way. They found that older people experience domestic abuse for twice as long as those under 61 and they are also far less likely to access services[24]. If domestic abuse was a continuous feature in Alice's life this may have pointed to why agencies had no knowledge of her.

10.19 It is also worth noting in the SafeLives report that 44% of the perpetrators of older people are adult family members, 73% experience coercive and controlling behaviour and there is a 'systematic invisibility' of older victims of DA due to their differing needs[25].

10.20 During interview David stated that his mother had been housebound since November 2013, however, GP records show that Alice attended the surgery four times between November 2013 and her death in May 2014. Her records further state that Alice was able to walk her dog for an hour with the aid of a stick. There is no suggestion from the GP that Alice would be considered housebound although problems with pain and mobility were documented.

10.21 Examination of all information provided to the DHR Panel reveals that David had not been attributed any responsibility as a carer for his mother. David stated that things were perfect until a few weeks before the murder.

10.22 There is some discrepancy between the account of David and the record of the GP in
relation to the incident in November 2013 and what Alice had disclosed. Whilst this incident does prompt questions as to why Alice did not seek medical attention when she had attended the surgery eighteen times in the two years leading to her death.[26]

Equality Act 2010

10.23 The Equality Act 2010 defines the following as protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex

[24] http://www.safelives.org.uk/spotlight-1-older-people-and-domestic-abuse
[25] http://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf p.5, 11 & 12
[26] 10.20, 10.21, 10.22 quoted from author two report.

- Sexual orientation

All of these characteristics have been considered throughout this process with mental health being addressed under 'disability'. The relevant characteristics were the age and the sex of the victim

10.24 Alice was 79 years old at the time of her death. GP records show that she had a number of health issue which could be considered symptomatic of her years. Alice did have some mobility issues but did not have any identified care needs at home. There is no suggestion of any financial abuse having occurred. The relevance of elder abuse has been considered in analysis and will further be considered in the recommendations.

10.25 The sex of the victim is relevant here as females are disproportionately the victims of homicide in domestic abuse cases. Research evidences that an average of 137 women across the world are killed by a partner or family member every day, according to new data released by the United Nations Office on Drugs and Crime (UNODC). The research further evidences that 58% of women are murdered by a partner or family member[27].

10.26 With respect to this DHR the conclusion is that none of the protected characteristics impacted the services offered to Alice.

11. Good practice

11.1 The police report made to the CPS describes how the attending officers were wearing body-worn video. The footage captured in real time, the crime scene, efforts to save the life of Alice and comments made by David. Body cameras provide valuable evidence in support of victims of domestic abuse and demonstrates good practice.

11.2 The Local Domestic Abuse Forum provides additional training opportunities and relevant literature to local GP Practices.[28]

12. Key findings

A) Routine Enquiry

Whilst it is clear that there is a strong record of partnership working in and across the Safer North Hampshire Community Safety Partnership like most areas across the country the use of routine enquiry for domestic abuse in health settings is sporadic.

[27] https://www.bbc.co.uk/news/world-46292919

[28] 12.1 & 12.2 information quoted directly from the second author report

The findings in this report point to a need to address the adoption of routine enquiry of all patients, particularly in relation to females.

B) Elder Abuse

At the time of the panel there was little research on the intersectionality of domestic homicide and age. The research and drivers available to us now enable us to understand the compounding factors of age and the propensity for domestic abuse, particularly on females from adult male sons. Current research offers us an opportunity to adapt and learn lessons about how older victims of domestic abuse may access services, particularly in relation to adult family members.

According to SafeLives national Insights dataset (2016), "44% of respondents who were 60+ were experiencing abuse from an adult family member, compared to 6% of younger victims. This presents some challenges to service providers who may not be used to recognising or responding to this form of abuse." In summarising SafeLives concluded that "This suggests that services need to have more awareness of domestic abuse in relation to the adult child and parent dynamic, as older people are experiencing further invisibility within this form of abuse."[29]

The most recent academic research, undertaken by Dr Hannah Bows, in 2018, points to the same conclusions.[30]

C) Social Isolation

Alice's death does raise important points on social isolation and the general public's understanding of these issues. It is apparent that Alice had a very small social circle and her main contact was with her son David. Social isolation in older people is something as a society we are tackling more openly. However, the social isolation of older people who are also experiencing domestic abuse can benefit a perpetrator's use of coercive and controlling behaviour as the victim's world is already very small.

In Alice's case all of the above could have pointed to why no other agencies knew of her, if she, or a women like Alice, was experiencing domestic abuse these issues are likely to have been a significant barrier to disclosure.

[29] http://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf p.16,17
[30] https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcy108/5211414

13. Recommendations

Single Agency Recommendations

13.1 The author felt that given the analysis of the report the bulk of recommendations would remain within a multi-agency context. No single agency was aware of any abuse.

Multi-Agency Recommendations

13.2 Address the information, training and multi-agency response health professionals could utilise, e.g. routine screening, to respond to potential victims of DVA.

13.3 Multi-agency response to elder abuse and the intersectionality of DVA and age in the context of domestic abuse, particularly from adult male sons.

13.4 Raise awareness to multi-agency partners of vulnerable adults in relation to DVA and in the context of social isolation.

13.5 Make accessible via training and awareness raising the understanding of Coercive Control, particularly in the context of the subsequent legislation.

National Recommendations

Governmental driver to raise the issue of elder abuse and Domestic Homicide. Utilising the most recent research available. Namely - *Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK – Hannah Bows (2018)*[31].

13.6 Given the amount of time that has passed since the murder of Alice it is pertinent to review the actions already carried out in the area since 2014.

13.7 The author of this report requested a statement from the chair of the North Hants DVA forum, Karen Evans. Karen also sat as the specialist on the panel in 2014 and as such had full understanding of the case and the points discussed at the time.

13.8 The following is a full response from the forum in relation to questions put to them via the third author:

[31] https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcy108/5211414

North East Hampshire Domestic Abuse Forum – Statement for DHR

Context:

As there was very limited known contact with agencies or understanding of any background or context to why this murder took place, the forum actions related to the following:

1) Increasing awareness of domestic abuse and elder abuse within the local community
2) Working with GP surgeries and the CCG to identify ways to increase access to information by and at GP surgeries
3) Increasing understanding of carer stress – although we weren't able to determine if this was a factor in this case, we are aware there can be huge pressures on families where there are care issues.

1. What work has the forum done in relation to the murder?

a) Convened meetings with CCG named leads to understand more about processes; information available at the surgeries; possibilities around introducing IRIS project and training for health.

b) Press releases around elder abuse – these focused on wider messages rather than directly linked to the murder and included articles published by Aldershot News group; Hart News and Rushmoor Arena publications. Example attached.

iti spring clean for Hart

Focus Week takes place
Graffiti Focus Week is an
ss the Hart area, in which we
f the issues of graffiti through
negative effect it can have on
e also aim to remove as
ossible from the local area.
visible initiative, which
l environment and helps to
ons of the local area. Since
ect a number of years ago,
fiti across the district have

The following tips may help to reduce the likelihood of graffiti:

- Plant climbing shrubs on exposed brick walls
- Plant hedges in front of wooden fences
- Install security lighting
- Report any graffiti by calling 101

If you are aware of any graffiti in your local area, report it to us by emailing communitysafetyteam@communitysafetynh.org, calling 01252 774476 or visit hart.fixmystreet.com

your home
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ier and longer evenings
th Hampshire
Team would like to
bout the importance of
ple home security tips
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dows that aren't in view
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Elder abuse – do you k someone who needs h

Did you know that an estimated half a million older people are abused and neglected every day in their own home by people they thought they could trust?

The abuser is often well known to the person being abused. They may be a partner, child, relative, friend, or neighbour, a paid or volunteer care worker, a health or social worker, or another professional. The abuse may also come from a person they care for.

You might wonder how this can happen, or it may be an everyday occurrence for you and may have come about, or become more concerning, because of mental or physical frailty; a life-changing event such as retirement or health problems; isolation or reliance on a perpetrator for financial reasons, medication or care. It may be that this suffering has been going on for many years.

Sometimes providing care for someone can become difficult, especially when there is a lack of the skills needed to provide the care, or people do not have the external support necessary to care for another person. This doesn't mean that the impact is less, but recognising these pressures and trying to get help for both the older person and the carer can help to relieve some of the pressures.

Many people who are affected by domestic abuse have said they suffered in silence as they were worried about the unknown, being left without a carer or companion, their finances, fear of negative reactions from family, friends or the wider community, desire to avoid outside parties becoming involved in a domestic situation or were worried about not being believed.

An important first step is finding someone to confide in. This could be a GP, nurse, social worker, police officer, neighbour, friend, relative or befriending service or social group. You could also think of speaking to the Action on Elder Abuse helpline on **020 8835 9280** if you have access to a phone and an opportunity to call them when there is no one to hear you making the call.

Information about local support for those affected by

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www.safe
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What you can do about anti-social

c) Targeted information published through Hart network of older people's groups – this has included information in their newsletters which are circulated to several thousand people; training and awareness raising sessions for their lead volunteers and talks to members.

d) Increased understanding through speakers at forum meeting and training events. The forum has bi-monthly meetings of its members and guest speaker slots are provided to increase understanding of practitioners. Alongside the forum meetings, regular multi agency training sessions are organised by the forum. Following the murder inputs were provided at both the meetings as well as at training sessions in order to upskill local practitioners on signs to be aware of, responses and signposting.

2. What work has the forum or other agencies done to raise the profile with health in Fleet or North Hants?

a) Following the meeting detailed above, closer links were forged with the CCG safeguarding lead for domestic abuse; designated nurse and GPs which have enabled us to look at resource provision and training across the GP surgeries in our wider area.

b) Strong links are in place with Frimley Park Hospital with the forum providing domestic abuse resource packs for all wards at the hospital; leaflets to be available in the Emergency Department; training for ED staff around domestic abuse; as well as involvement with the safeguarding teams at the hospital and development of DA pathways.

c) More recently, links have been made with Hampshire Hospitals (who are based in Basingstoke) and support provided in terms of training; awareness raising input and signposting information and leaflets.

d) All GP surgeries are now visited by the Named GP for domestic abuse, CCG who talks to the doctors and staff about domestic abuse to ensure resources are available and relevant training provided.

e) The forum worked in partnership with the GP training lead to organise a training day for all GPs, Practice nurses and paramedics around domestic abuse and mental health – this was attended by 120.

f) There is now a domestic abuse pathway in place across Hampshire health settings – this was primarily finally put in place following the JTAI inspection around domestic abuse and children but covers all those affected by domestic abuse. Roll out took place mid-2018.

f) The forum has delivered many training and awareness sessions for SECAmb staff (who cover our area), working with the safeguarding team.

g) The forum also works closely with the armed forces and domestic abuse input has been delivered to Army GPs and dentists based in our area – although this doesn't directly relate to the elder nature of the DHR.

3. Has there been any work in the area around coercive control?

a) Prior to the introduction of the CCB legislation, the forum arranged a Multi-agency training session to enable local practitioners to be prepared for this legislation – the input included guest speakers from the CPS as well as a male victim of coercive control.
b) The forum chair is a College of Policing associate and was involved with the piloting and early roll out of the DA Matters training programme. The forum chair continues to be involved with the DA Matters programme now being delivered for Hampshire police and is a Safelives associate.
c) The forum chair is a member of the Wessex CPS scrutiny panel so is able to keep current with CCB implementation and opportunities, which are shared as appropriate with the forum members.
d) Press releases linked to CCB

4. Has there been any work around elder abuse / vulnerable adults?

a) The forum chair is a member of the Hart Ageing Well forum which brings together the many local older people's group leaders. Through this group, contacts have been made which enable a wider sharing of information to the older population and those who are seeking to support them.
b) Awareness sessions have been delivered as above and a multi-agency training event was held last month on Adults at Risk (Vulnerable Adults). This training included looking at older people; those with physical and mental disabilities; those with learning difficulties; alcohol and substance misuse and complex needs.
c) The Action on Elder Abuse training resource has been purchased by the forum which is available to older people groups in our area
d) The forum membership includes Adult Services, the Surrey and Borders Trust Learning Disability Team; mental health services; older people's forum and many others who are working to support vulnerable adults – these members share their expertise and raise awareness of their services criteria and referral pathways.
e) Citizens Advice locally are rolling out their ASK project which is around including asking about domestic abuse within their initial assessment for all clients (with the exception of consumer issues). Rushmoor CA adopted the project 2018, Hart will be early 2019.

Is there anything else the forum or you did after the murder to address some of the above issues or anything else you want to add?

Following the murder and to date we continue to try and gain more of an understanding of the way in which people access information about domestic abuse and look at covert ways in which questions can be raised (for example through including questions on domestic abuse / home situation within routine appointments)

We also continue to try and increase our understanding of the impact of carer stress and how the agencies can try to ensure that vulnerable adults and carers aren't under the radar and that those who are struggling, are more aware of support available.

In Hart, we are extremely lucky that there are a huge amount of services available to older people delivered through a network of volunteers where people are willing to access these.

The Basingstoke Over 55s directory covers a lot of local services
https://www.basingstoke.gov.uk/content/doclib/2563.pdf

13.9 It is clear from the above statement that the response to Alice's murder was taken seriously and actions have been robustly thought out and executed in the years preceding her death. The author has therefore suggested a short follow up of additional actions which are detailed in the action plan.

14. Action Plan

Domestic Homicide Review into the Murder of Alice (Adult F)

Type	Recommendation	Suggested Actions	Responsible Department/ Agency	Completed Date
Single Agency	N/A – see 14.1	N/A	N/A	N/A
Multi Agency	Address the information, training and multi-agency response health professionals could utilise, e.g. routine screening, to respond to potential victims of DVA.	Analysis of work done within the Safer North Hampshire Community Safety Partnership area with regards to health professionals since the murder of Alice – utilise local and national research including IRISi[32] project to develop responses	West Hampshire CCG (as Safeguarding lead for NE Hants & Farnham CCG)	July 2019– Domestic Abuse pathway for health agreed and rolled out across Hampshire. This includes routine questioning and domestic abuse health pathway
	Multi-agency response to elder abuse and the intersectionality of DVA and age in the context of domestic abuse, particularly from adult male sons.	Utilising research undertaken by SafeLives on their Spotlight on Elder Abuse[33]. Ensure key stakeholders and commissioners are aware and have sight of the research report Safe	North East Hampshire Domestic Abuse Forum	November 2018, multi agency training delivered and information circulated to agencies. Ongoing input at Ageing Well meetings and forum meetings and research circulation

[32] http://www.irisdomesticviolence.org.uk/iris/
[33] http://www.safelives.org.uk/spotlight-1-older-people-and-domestic-abuse

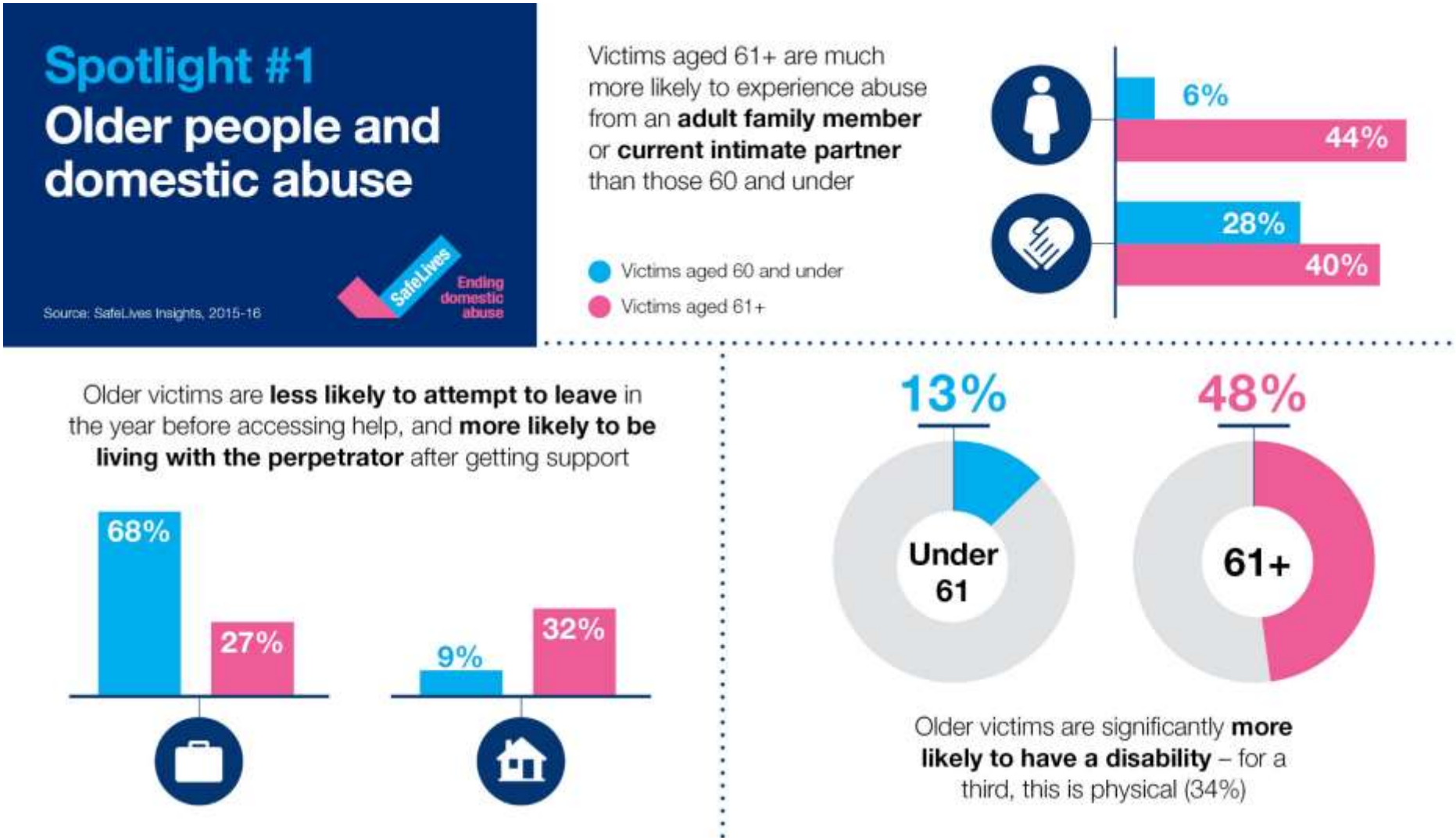
		Later Lives[34]. Using the info graphics provided in the report engage professionals/ victims via online mechanisms (including social media) to foster critical thinking and enquiry with regards to elder victims of DVA (See example 1)		
	Raise awareness to multi-agency partners of vulnerable adults in relation to DVA and in the context of social isolation	Using the most recent research undertaken by Dr Hannah Bows[35] work with the Hampshire Safeguarding Adults Board to raise the profile of the recommendations and conclusions in the above research (see example 2)	Adult Services / HSAB	
	Make accessible via training and awareness raising the understanding of Coercive Control, particularly in the context of the subsequent legislation	Coercive control is integral to all training delivered and information shared with members.	North East Hampshire Domestic Abuse Forum	2015 Prior to legislation being introduced multi agency training delivered – CC embedded in training in addition to information

[34] http://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf
[35] https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcy108/5211414

				being available to forum members
National	Governmental driver to raise the issue of elder abuse and Domestic Homicide. Utilising the most recent research available.	Government to utilise the most recent research - *Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK – Hannah Bows (2018)*[36]. Ensuring guidance, strategies and funding enables and fosters a proportionate focus on DVA elder abuse and Parricide for specialist domestic abuse providers across the UK.	Home Office	

[36] https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcy108/5211414

Example 1


Spotlight #1
Older people and domestic abuse
Source: SafeLives Insights, 2015-16
SafeLives
Ending domestic abuse
Victims aged 61+ are much more likely to experience abuse from an **adult family member** or **current intimate partner** than those 60 and under
Victims aged 60 and under
Victims aged 61+
6%
44%
28%
40%
Older victims are **less likely to attempt to leave** in the year before accessing help, and **more likely to be living with the perpetrator** after getting support
68%
27%
9%
32%
13%
48%
Under 61
61+
Older victims are significantly **more likely to have a disability** – for a third, this is physical (34%)

Example 2

- In England, the Care Act 2014 introduced an overall framework within which adult safeguarding is situated, whilst the 2012 Domestic Violence, Crime and Victims Act (Amendment) locates identifying and responding to DV as multi-agency responsibility. Combined, the legislation and associated policies and guidance create a broad set of statutory duties for adult social workers to identify, investigate and respond to violence and abuse of adults. Two examples include working with stakeholders to assess risk and develop safeguarding plans through Multi-Agency Risk Assessment Conferences and, where violence or abuse (or, in the case of older adults, neglect) leads to death, through involvement in Domestic Homicide Reviews and Safeguarding Adult Reviews.
- However, in practice, there is a disconnect between the legislation, policy and practice approaches and social workers remain confused about their role in relation to both EA and DV (Robbins *et al.*, 2016[37]). The existing guidance on EA and DV is distinct, resulting in older victims falling through the gaps (Wydall *et al.*, 2018[38]) due to different pathways created by adult safeguarding and DV policies and practice
- Multi-agency working must also extend to include those working in related disciplines and industries, including age-related organisations, health and social care.[39]

[37] Robbins, R., Banks, C., McLaughlin, H., Bellamy, C. and Thackray, D. (2016) 'Is Domestic Abuse an Adult Social Work Issue?', Social Work Education, 35(2), pp. 131–43
[38] Wydall, S., Clarke, A., Williams, J. and Zerk, R. (2018) 'Domestic abuse and elder abuse in Wales: A tale of two initiatives', British Journal of Social Work, 48(4), pp. 962–81.
[39] https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcy108/5211414

15. Appendix A – Home Office Letter

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Caroline Ryan
Community Safety Manager
Safer North Hampshire

27 October 2017

Dear Ms Ryan,

Thank you for submitting the Domestic Homicide Review (DHR) report for Hampshire to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 20 September 2017. 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 was grateful for the information on the delays in submitting this report and the challenges in getting it completed. However, the Panel was concerned that there is insufficient probing and little professional curiosity considered in the report. At only 13 pages, the report felt rushed, lacks detail and is light on analysis.

While there was no domestic abuse identified by the review, it would be helpful if the report could articulate that the dynamics of this behaviour were considered as part of the analysis. More specifically, the review describes the fact that the perpetrator and victim lived private lives, but there is no examination of whether coercive control and isolation were factors in this case.

You mention that there was a breakdown in relationship between the panel and chair which meant the DHR process had to be taken back to its early stages. The Panel would welcome further detail on what contributed to the difficult relationship. The statutory guidance recognises that disputes between review panel members can be healthy and form the basis of rigorous challenge, but they need to be resolved by the review panel and chair. If they cannot be resolved, the DHR report should record the areas of disagreement and actions taken towards a resolution.

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

- The review does not examine why the victim had no contact with agencies other than her GP and whether there were any barriers to reporting, which the Panel felt were critical to this review;

- There were issues around flagging, referrals and adult safeguarding procedures but these have not been adequately explored. This should also examine whether existing policies and procedures remain effective;

- The absence of contributions from the victim's family and friends gives the victim a limited voice in the report;

- The Panel thought it may have been helpful to interview the perpetrator's work colleagues;

- There is no examination of whether the victim discussed home life with her other son. Additionally it would help if the review could clarify why the victim's other son would not engage with the DHR process;

- No action plan or executive summary was submitted with the report. The Panel would normally expect to see three separate documents as in the templates set out in the statutory guidance;

- It may have been helpful to have engaged a domestic abuse specialist on the review panel;

- There is no information on the independence of the original chair or the second appointed author;

- Pseudonyms would have made the narrative easier to follow and would help humanise the review;

- The precise date of the homicide should be removed to enhance anonymity;

- The Panel questioned the relevance of part one and part two in the report;

- Please spell out acronyms in full the first time they are used;

- The report needs a full proof read as there are a number of typing errors.

The Panel would be grateful if you could provide a revised version of the report with the changes suggested, together with confirmation of your publication intentions, by 15 December 2017. Please clearly indicate where changes have been made in the revised report, and make it clear in the subject line of your email when resubmitting that the documents contained are revised versions for reconsideration. Please let me know if this will prove difficult.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel

16. Appendix B

Annex 1 - Domestic Homicide Review Terms of Reference for AK

This Domestic Homicide Review is being completed to consider agency involvement with **Alice** and her son, **David**, following her death in **May 2014**. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with **Alice** and **David** during the relevant period of time: **May 1st 2012 – May 31st 2014.**

3. To summarise agency involvement prior to **May 2014**.

4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

7. To commission a suitably experienced and independent person to:

   a) chair the Domestic Homicide Review Panel;

b) co-ordinate the review process;
c) quality assure the approach and challenge agencies where necessary; and
d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

9. On completion present the full report to the Home Office Domestic Homicide Review Panel and local Community Safety Partnership.

Membership

10. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Your agency representative must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.

11. The following agencies are to be involved:
    a) Clinical Commissioning Groups (formerly known as Primary Care Trusts)
    b) General Practitioner for the victim and perpetrator
    c) Local domestic violence specialist service provider e.g. IDVA
    d) Education services
    e) Children's services
    f) Adult services
    g) Health Authorities
    h) Substance misuse services
    i) Housing services
    j) Local Authority
    k) Local Mental Health Trust
    l) Police (Borough Commander or representative, Critical Incident Advisory Team officer, Family Liaison Officer and the Senior Investigating Officer)

m) Prison Service
n) Probation Service
o) Victim Support (including Homicide case worker)

12. Where the need for an independent expert arises, for example, a representative from a specialist BME women's organisation, the chair will liaise with and if appropriate ask the organisation to join the panel.

13. If there are other investigations or inquests into the death, the panel will agree to either:
    a) run the review in parallel to the other investigations, or
    b) conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Collating evidence

14. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

15. Each agency must provide a chronology of their involvement with the **Alice** and **David** during the relevant time period.

16. Each agency is to prepare an Individual Management Review (IMR), which:
    a) sets out the facts of their involvement with **Alice** and/or **David**;
    b) critically analyses the service they provided in line with the specific terms of reference;
    c) identifies any recommendations for practice or policy in relation to their agency, and
    d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

17. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the

partnership which could have brought **Alice** or **David** in contact with their agency.

Analysis of findings

18. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
    a) Analyse the communication, procedures and discussions, which took place between agencies.
    b) Analyse the co-operation between different agencies involved with the victim, perpetrator, and wider family.
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations access to specialist domestic abuse agencies.
    f) Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and perpetrator's family

19. Sensitively involve the family of **Alice** in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the perpetrator's family who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.

20. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

21. Coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.

Development of an action plan

22. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.

23. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

Media handling

24. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

25. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

26. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

27. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

28. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

Disclosure

29. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.