Bassetlaw Newark & Sherwood Community Safety Partnership

Domestic Homicide Review Report:

‘Cynthia’

Tony Blockley
Paul Johnston

Director: Johnston and Blockley Ltd

Date: 24 May 2018

1 Preface

The Bassetlaw, Newark & Sherwood Community Safety Partnership Domestic Homicide Review Panel would like to express its profound condolences and sympathy to Cynthia's family.

At all times the panel has tried to view what happened through Cynthia's eyes. We would like to assure them all that in undertaking this review, we are seeking to learn lessons to improve the response of organisations in cases of domestic abuse.

The independent chair and author of the review would also like to express his appreciation for the time, commitment, and valuable contributions of the review panel members and contributing report authors.

The key purpose of undertaking a Domestic Homicide Review is to enable lessons to be learnt from homicides where a person is killed because of domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening again. Cynthia's death met the criteria for conducting a Domestic Homicide Review under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004, in that his homicide appeared to have been by the hand of a person to whom he was related, or with whom he had, or had been in an intimate relationship.

The Home Office defines domestic violence as:

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

Controlling behaviour is: 'A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of

the means needed for independence, resistance and escape and regulating their everyday behaviour.'

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

The term domestic abuse will be used throughout this review where possible, as it reflects the range of behaviour encapsulated within these definitions and avoids the inclination to view domestic abuse in terms of physical assault only.

2 Introduction

3 The Circumstances that led to this Domestic Homicide Review (DHR)

4 This Domestic Homicide Review Overview Report is about Cynthia, a 93-year-old woman, who died in Nottinghamshire, in August 2016 after having been suffocated by her husband ‘Bill’.

5 Cynthia and Bill had been married for 69 years and up until recently had been in good health. Following a stroke in 2015, Cynthia had become effectively bed ridden and was suffering from Alzheimer’s. Cynthia and Bill had arranged a pact between themselves, that should one of them become bedridden and their health deteriorated they would end the suffering rather than being placed in a home On the day of her death in August 2016, Cynthia was suffocated by Bill at her home, a home they shared with Bill’s son and his wife. Immediately after Cynthia’s death Bill attempted to take his own life but was unsuccessful.

6 Cynthia and Bill are pseudonym’s chosen by the panel. Their family have been approached directly through the police family liaison officer to take part in the review but have declined. This method of approach was seen as the most appropriate given the circumstances and that Nottinghamshire police had no involvement or contact with Cynthia and Bill prior to her death and therefore remained effectively independent.

Initially Cynthia and Bill’s grandchildren indicated they would want to take part in the review but they have since decided that they did not want to.

On completion of the review, the family will have the opportunity to see the report and this will be a chance to engage with the review if they wish to do so.

7 Bill was charged with Cynthia's murder, which was later, changed to manslaughter. Bill was found guilty at Nottingham Crown Court in June 2017 on the grounds of diminished responsibility after fully admitting his part and was sentenced to 12 months imprisonment, suspended for two years.

8 During the court proceedings, the judge said:

"It is not necessary for the court to add further to the tragedy of this case by the imposition of a sentence of immediate imprisonment."

However, he said, "this was a crime", and [Bill] had taken the life of another person.

"Every life is uniquely precious," he said. "The sanctity of life is one of the hallmarks of a civilised society and our justice system"… "This is not a case of assisted suicide. This was a killing as a perceived act of mercy"… "However, it is central to this case that [Cynthia] had repeatedly asked her husband to ensure that she did not suffer; to kill her rather than let her endure pain and indignity"… "In a sense, [Bill's] actions were coolly and calmly rational - fulfilling his promise to his beloved wife"… "In fact, he was acting through the fog of his distress, his depression and his declining mental faculties, in particular his misapprehension that he and his beloved wife were about to be separated."

9 Following notification of the homicide and the decision to hold a domestic homicide Review in July 2017 agencies were asked to review their records to identify any contact they had with either Cynthia and/or Bill.

Since the commencement of the review, Bill has passed away.

10 No agency had any information relating to domestic violence or abuse.

Health agencies had information relating to a stroke that Cynthia had suffered in August 2015 and other minor medical conditions, but other than that no information or contact. Bill had also had contact with health agencies regarding medical conditions commensurate with his age, but nothing with regard to domestic violence or abuse.

11 The review considered the lack of information and contemplated the purpose of the review. It was recognised that the review was to learn lessons going forward and the focus of the review was not necessarily to identify what agencies did or did not do, but rather whether there had been evidence of abuse in the relationship and what barriers there were to reporting such abuse.

12 Whilst there were no indications of abuse there were some behaviours, which the panel thought should be considered in light of the review and these are commented on within the report. It is clear from the police investigation there was no evidence of abuse and no evidence that would suggest coercive and controlling behaviour in the relationship.

13 Given this backdrop the review considered in great depth whether there was abuse and whether there were barriers to reporting. Despite intensive investigation, consideration and discussions, there were no indications of domestic abuse.

14 **Establishing the Domestic Homicide Review**

On 26th July 2017, the Community Safety partnership met to discuss the case and determined that a DHR should be undertaken. The Home Office was duly notified.

The review panel considered all the available information and considered that given the circumstances and the lack of agency involvement the review should be a proportionate one.

15 **DHR Panel Chair**

Tony Blockley, an Independent Chair was appointed by the Bassetlaw, Newark & Sherwood Community Safety Partnership. He is a specialist independent consultant in the field of homicide investigation and review. He has senior management experience in all aspects of public protection. He has been involved in numerous homicide reviews throughout the UK and abroad, was chair of MAPPA and was responsible for all public protection issues when he was head of crime in a UK police force. He has been involved in numerous DHRs, serious case reviews and MAPPA reviews. He is also a special advisor to a 3rd sector organisation that provides domestic abuse services (not in the area covered by the Bassetlaw, Newark and Sherwood Community Safety Partnership) and is a Senior lecturer in criminology at the University of Derby.

16 **Overview Report Author**

Paul Johnston, an Independent report author was appointed by the Bassetlaw, Newark & Sherwood Community Safety Partnership. He has senior management experience in many aspects of homicide revi ew and investigation and has been involved in several domestic homicide reviews in England and Wales. He has been a special advisor to an organisation that provides domestic violence and sexual abuse services, including a male perpetrator programme and IDVA service for high-risk victims.

He is a member of an international investigation facility into sexual and gender based violence in conflict zones and is a consultant to an independent European human rights Advocacy service that seeks to secure justice for victims of human rights abuses, mainly in Eastern Europe.

He is currently acting as an expert witness in several cases before the European Court of Human Rights involving abduction, murder and domestic abuse femicide.

17 **The DHR Panel**

The Domestic Homicide Review Panel on behalf of Bassetlaw, Newark and Sherwood Community Safety Partnership agreed the formation of the overview panel comprising of agencies that could potentially have information regarding the couple. Other agencies were also invited, including a representative providing specialist domestic violence advice.

18 **The DHR Review Panel consists of:**

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Name	**Organisation**
Tony Blockley	Independent Chair and Author
Nicolette Richards	Domestic Violence Co-ordinator Bassetlaw, Newark & Sherwood Community Safety Partnership
Gerald Connor	Community Safety Manager Bassetlaw District Council
Elizabeth Boyle	Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.
Denise Scott	Nottinghamshire County Council Adult Social Care
Leigh Sanders	Nottinghamshire Police
Andrew Beardsall	Bassetlaw Clinical Commissioning Group
Susan Barnitt	Newark and Sherwood Clinical Commissioning Group

Ben Adams	Newark and Sherwood District Council
Lucy Binch	Nottinghamshire Women's Aid
Marlene Ferris	Newark Women's Aid
Julie Gardner	Nottinghamshire Healthcare NHS Foundation Trust.
Val Lunn	WAIS

20 Scope of the review

The DHR panel determined that the review should focus on the period between 1st August 2015 and 3rd August 2016, the date of Cynthia's death. The starting point was identified as an opportunity to determine what records were held.

Due to the lack of any information agencies went back beyond August 2015, some to 1996 and 2001 without identifying any significant information for the review

21 Terms of reference

The purpose of the review was 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 coordinated 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.

22 Due to the limited information and nothing to suggest domestic violence or abuse the review panel considered the applicability of the use of the terms of reference within the statutory guidance. It was felt that much of the detail was unnecessary and therefore would not be commented on. Factors such as whether it was appropriate to refer to MARAC, whether MAPPA arrangements were in place or that Bill should have been on a perpetrator programme, Cynthia's contact with domestic abuse organisation or helpline There was no possibility of abusive behaviour in previous relationships as they had been married for 69 years.

The review felt it was unnecessary to focus on the role and response by individual agencies relating to domestic abuse as neither Cynthia nor Bill had accessed agencies and those medical organisations they had been in contact with were for unconnected medical matters.

However, to ensure that nothing was missed it was essential that agencies kept these points in mind and the chair of the review was acutely aware of the need to offer critique and question any behaviours or processes.

Following review of the guidance and factors for consideration, the following areas for consideration were felt to be applicable.

- Whether the incident in which Cynthia died was an isolated one or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse.

- Whether there were any barriers experienced by Cynthia or her family and friends in reporting any abuse in Nottinghamshire or elsewhere, including whether they knew how to report domestic abuse should they have wanted to?

- Whether there were opportunities for professionals to 'enquire' as to any domestic abuse experienced by Cynthia that were missed.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Cynthia or Bill that were missed.

- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the area covered by the Bassetlaw, Newark and Sherwood Community Safety Partnership.

- The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to Cynthia or Bill e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

23 Under the management of the review the panel also gave consideration to the following factors:

- How should friends, family members and other support networks and, where appropriate, the perpetrator, contribute to the review and who should be responsible for facilitating their involvement?

- How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for it.

- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?

- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

- How should the review process take account of previous lessons learned from research and previous DHRs?

- Whether Cynthia or Bill were 'vulnerable adults'

- Whether there were any issues in communication, information sharing or service delivery between services.

24 It was felt that the review would need to consider a number of case specific issues to ensure that appropriate examination and inquiry was made of the information. Specific to the review were the following points

- To examine whether agencies operated within an environment that allowed for a presumption of needs for Cynthia and/or Bill, without taking their views and thoughts into account

- Was there appropriate consideration for their welfare or was there evidence of an aged based assessment

- Did agencies take into account the isolation the recent move to another address could have created and were those concerns articulated or mitigated

- Were the wider care issues for Cynthia and Bill considered and how were they or could they be considered in the future

- Is there evidence of the effective transference of agency responsibilities considering neighbouring areas and cross boundary working

25 Research in this area is limited, however where available that research has been utilised.

The following documents have been considered

- The Home Office multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews 2013
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers 2012
- Call an End to Violence Against Women and Girls – HM Government (February 2016)
- Barriers to Disclosure – Walby and Allen, 2004.[1]
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.

[1] Walby, S. and Allen, J., 2004. *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey*. Home Office.

- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, 2006.
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire - July 2007 [2]
- Patterns of intimate partner homicide suicide in later life: strategies for prevention[3]
- What is domestic violence and how common is it? In Intimate Partner Abuse and Health Professionals: New Approaches to Domestic Violence - Hegarty 2006 [4]
- Suicide and assisted dying in dementia: what we know and what we need to know. A narrative literature review [5]
- External Barriers to Help Seeking for Older Women Who Experience Intimate Partner Violence[6]
- Responding to the Needs of Older Women Experiencing Domestic Violence[7]

26 Participating Agencies

The following agencies were asked to provide chronological accounts of their contact with Cynthia and/or Bill.

- Bassetlaw Newark & Sherwood CSP

[2] Regan, L., Kelly, L., Morris, A. & Dibb, R. (2007). 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire. London: London Metropolitan University Child and Woman Abuse Studies Unit.

[3] Salari, S. (2007). Patterns of intimate partner homicide suicide in later life: Strategies for prevention. *Clinical Interventions in Aging*, *2*(3), 441–452.

[4] Roberts G, Hegarty K, Feder G, editors. Intimate partner abuse and health professionals: new approaches to domestic violence. Edinburgh: Churchill Livingstone; 2006. pp. 19–40.

5 Diehl-Schmid, J., Jox, R., Gauthier, S., Belleville, S., Racine, E., Schüle, C., Turecki, G. and Richard-Devantoy, S. (2017) "Suicide and assisted dying in dementia: what we know and what we need to know. A narrative literature review," International Psychogeriatrics, Cambridge University Press, 29(8), pp. 1247–1259.

[6] Beaulaurier, R., Seff, L., Newman, F. and Dunlop, B. (2007). External Barriers to Help Seeking for Older Women Who Experience Intimate Partner Violence. Journal of Family Violence, 22(8), pp.747-755.

7 Straka, S. and Montminy, L. (2006). Responding to the Needs of Older Women Experiencing Domestic Violence. Violence Against Women, 12(3), pp.251-267.

- Doncaster & Bassetlaw Teaching Hospital's NHS Foundation Trust.
- Nottinghamshire County Council Adult Social Care
- Nottinghamshire Police
- Bassetlaw CCG
- Newark and Sherwood CCG
- Newark and Sherwood District Council
- Nottinghamshire Women's Aid
- Nottinghamshire Healthcare NHS Trust.

Parallel processes

27 Although Cynthia's death was referred to the Coroner, no inquest took place because all the evidence and information about it was aired during the criminal proceedings in recognition of the Coroners and Justice Act 2009.

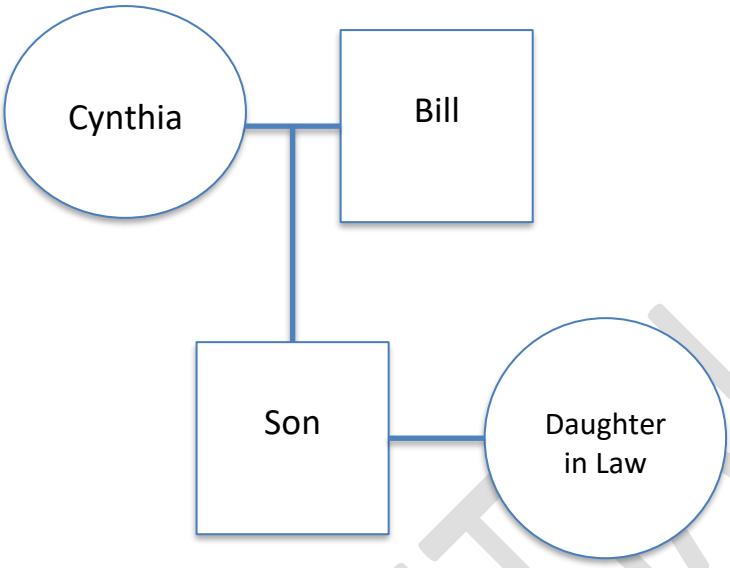
28 **The involvement of family members**

The DHR Panel would like to extend its sincere condolences to Cynthia and Bill's family. Whilst they have indicated they do not wish to take part in the review at this time they will be notified of the completion of the report and should they wish to engage at that point in time the panel will facilitate this.

Cynthia and Bill's son and daughter in law were contacted and did not want to take part. Their children, Cynthia and Bill's grandchildren were also contacted via the police family liaison officer and whilst they initially wished to take part, they decided not to.

Bill was also approached through the manager of the care home where he is now living and he did not want to take part in the review and given his age and the circumstances the panel fully respect his position.

29 **Family composition**



30 **Circumstances**

The following circumstances provide outline detail of the relationship between Cynthia and Bill following Cynthia's stroke in 2015 and up to the point of her death in August 2016.

31 In August 2015, Cynthia suffered a stroke and was admitted to Doncaster Royal Infirmary and then onto Bassetlaw hospital.

32 At the time of her stroke Cynthia and Bill were living in a small warden controlled flat and were not in receipt of any community care services, they were able to live a full and independent life with Cynthia taking on the care responsibilities for Bill. Even at the time of her admittance, Cynthia was keen to be discharged to return home so she would be able to look after Bill. It was recognised that any discharge would have to be carefully managed and being discharged to their current home would be difficult due to the equipment required and the size of the flat.

33 It became apparent that due to the stroke and subsequent impact this had on her Cynthia would not be able to live an independent life with Bill.

34 Following a period of hospitalisation Cynthia's family identified and moved into a property that would be able to accommodate them, Cynthia and Bill. With support from health carers the family were able to provide the ongoing care needs for Cynthia.

35 In May 2016, the arrangements caring for Cynthia were becoming a challenge and it became apparent that Cynthia and Bill would have to move into a care home

36 At the start of August discussions took place between the family, including Cynthia and Bill and a suitable care home was found that would be able to accommodate both of them and they were both due to move in the following Monday (6 days away). Two days later and four days before the move to the care home, Bill killed Cynthia

37 **Lessons to be learned from the review**

The review into the death of Cynthia was limited due to the circumstances and lack of agency involvement relating to domestic abuse.

There is clear evidence of the care provided to Cynthia and Bill following Cynthia's stroke and the efforts by agencies for them to remain together, which was their express wish.

Both Cynthia and Bill were recognised as vulnerable due to their age and Cynthia's stroke although their needs were managed and supported through the care package provided. It was their express wish to be together and this was a factor in the decisions relating to their care.

38 **Conclusions**

This was a tragic case, Cynthia and Bill were in their 90's, they had capacity and were able to make decisions to meet their needs and had the support of their family. Their express desire was to be together and agencies facilitated this with appropriate care and support.

There was no evidence or suggestion of abuse and nothing to identify or predict homicide. There is little in the way of learning from the review as both Cynthia and Bill were supported and given care, commensurate with their needs.

39 **Recommendations**

There is some learning from the review relating to carers' assessments and an understanding that the loss of independence may have had on the couple. The recommendations are part of the panels deliberations to develop services and not indicative of any failings.

To conduct a review of carer's assessments and consider how they identify or enquire into domestic abuse based in the challenges associated with domestic abuse, age and carer responsibilities from spouse/partner.

Provide greater awareness to professionals regarding the impact of age on domestic abuse, the barriers to reporting and the provision of services to older people.