Domestic Homicide Review C8

Arising from the death of

Mrs J – December 2015

Safer Devon Partnership

on behalf of

East and Mid Devon Community Safety Partnership

Overview Report

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Introduction

Purpose

1. This report of a domestic homicide review for Safer Devon Partnership examines agency responses and support given to Mrs J, a resident of East Devon, prior her death in December 2015. In addition to agency involvement, the Review examines the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the Review seeks to identify appropriate solutions to make the future safer.

2. Mrs J was killed by her fiancé Mr F. She was then aged 71 and he was 66. Both were widowed, of White British ethnicity, and had been living together at his family home, House M in Town N, for most of the year. Mr F reported the death to the police but died in prison shortly before the case came to trial. The Review Panel offers condolences to all those affected by these deaths.

3. The review considers agencies' involvement with Mrs J during 2015, and with Mr F between 2013 and 2015. This covers the period following the death of Mr F's wife Mrs F, during which the relationship between Mrs J and Mr F, who had known each other for many years, became close.

4. The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Confidentiality

5. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. Pseudonyms are used in this report to protect the identity of the people involved.

Timescales

6. Preparatory work on the review began in June 2016 following Mr F's plea of "not guilty" to the charge of murder at the end of May. While the trial did not take place, he had admitted the killing and was expected to plead guilty to manslaughter with a defence of diminished responsibility. His trial was

scheduled for July 2016, but he took his own life in prison in June[1]. HM Coroner therefore resumed the inquest into the death of Mrs J. Safer Devon Partnership agreed to the Coroner's request that the domestic homicide review should not start until after the inquest. Following the verdict, in January 2017, of unlawful killing, further work was done to confirm the Review Panel membership and assemble information prior to the first Panel meeting in April 2017.

7. The Review was concluded in May 2018. National guidance says that the overview report should be completed, where possible, within six months of the review starting. This was not achieved, with delaying factors including finding the appropriate way to gain information about primary health care; and allowing Mrs J's friends sufficient time to decide whether to engage with the Review. However, early learning from the Review has been taken into account in developing Devon's approach to domestic abuse, complementing the findings from other domestic homicide reviews involving older victims. A draft report was sent to the Home Office for Quality Assurance in June 2018 and the response received in November 2018

Dissemination

8. This report is published by Devon County Council for Safer Devon Partnership, with distribution to agencies as outlined in Appendix A.

Terms of Reference

9. The agreed terms of reference reflect Home Office guidance on domestic homicide reviews and set the purposes of the review as to:

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

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

    c) identify clearly how and within what timescales any recommendations will be acted on, and what is expected to change as a result;

    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

[1] The inquest into Mr F's death gave a verdict, in March 2018, of suicide.

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.

10. The Panel agreed, in the light of the initial information available, that the review should focus on the following questions.

   a) Was there domestic abuse (either way) between Mr F and Mrs J prior to the homicide?

   b) What opportunities did Mrs J and Mr F have to seek support in dealing with any domestic abuse? What might have hindered either of them from using these?

   c) If Mrs J or Mr F did seek support from public agencies, was the response appropriate?

   d) Did any agency during 2015 have information about Mrs J or Mr F that should have triggered further assessment, intervention or signposting of advice that could have protected her?

   e) Are there lessons about how to help older people in Devon to recognise domestic abuse and seek or signpost appropriate support?

   f) Are there lessons about risks faced by older people who relocate when starting a new relationship, and ways to mitigate them?

11. In setting these terms of reference, and examining the evidence, the Panel considered the nine protected characteristics under the Equality Act 2010.

12. Both Mrs J and Mr F were widowed, and some facts about the family histories are included as context. It is not within the remit of this Review to make comment on their marriages. However, some discussions Mr F had with health services about his relationship with his late wife are relevant to understanding his state of mind during the period covered by this Review. These are therefore included, with the caveat that they give only his point of view.

Approach

Decision to undertake a review

13. In Devon an Executive Group accountable to Safer Devon Partnership oversees the response to deaths potentially requiring a domestic homicide review under section 9 of the Domestic Violence, Crime and Victims Act (2004), which came into force in April 2011. Through a locally agreed protocol the community safety partnerships in Devon meet the requirements of the Act through the Safer Devon Partnership. Membership of the Executive Group is listed in Appendix A.

14. Devon & Cornwall Police referred the death of Mrs J to Safer Devon Partnership as a potential domestic homicide on 8th Dec 2015. In line with the protocol, the Domestic Homicide Review Co-ordinator for Safer Devon Partnership then asked agencies in Devon to check records of their contacts with Mrs J and Mr F. In the light of a summary of information compiled, as a homicide in which the victim and perpetrator were in an intimate relationship, the Executive Group agreed at their meeting in May 2016 to initiate a domestic homicide review, and appointed an Independent Chair.

Evidence considered

15. The following agencies provided detailed information for the domestic homicide review process. Those shown in bold were also asked to prepare an Internal Management Review which is an internal report whose author was not involved in the events. Further information about the Internal Management Reviews received is given in Appendix B.
    - Devon and Cornwall Police (based on the criminal investigation)
    - **Devon Partnership NHS Trust**
    - **Royal Devon and Exeter NHS Hospitals Trust**
    - South Western Ambulance Services NHS Trust.

16. The Review sought input from the primary care practice where the General Practitioners (GPs) for both Mrs J and Mr F were based, Town N Surgery. This was initially difficult due to uncertainty about the role and capacity of North, East and West Devon Clinical Commissioning Group in facilitating engagement of GPs in domestic homicide reviews. Communication via the police with GPs who had given statements to the criminal investigation proved more fruitful. The outcome was that the Panel saw, with permission, statements by three GPs, which drew on the full records held by the practice. The Independent Chair[2] also spoke to four of these GPs about what they knew of the relationship and their views of role of primary care in responding to domestic abuse.

[2] The Adult Social Care Panel member joined two of these interviews.

17. Additional sources of evidence were as follows.

- The insights of people who had known Mrs J and Mr F were sought as discussed below.
- The Safer Devon Partnership Domestic Homicide Review Co-ordinator attended the inquest on the death of Mrs J, and the Coroner granted access to selected evidence tabled at the inquest.
- Splitz and East Devon District Council provided information about domestic abuse services and awareness raising campaigns covering Town N at the relevant time.
- On request from the local Relate centre, the national Head of Service Quality and Clinical Practice provided information on relevant policies and practice of the charity[3].

Involvement of family, friends and wider networks

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

19. Application of this principle in this Review has been limited by the fact that Mrs J had no living relatives. She had no children, and, in giving a standard medical history in 2015, told a doctor that she had lost track of her family early on. Her husband Mr J died in 2008, and his children by a previous marriage had never formed a relationship with her. The Panel's view is that there is no-one with a close enough connection to Mrs J to be treated as "family" in the terms of the Home Office Guidance on domestic homicide reviews.

20. A friend, Ms Z, who had lived near Mrs J in Wiltshire, was the executor of her will, but did not respond to invitations to contribute views to the review. The Review Panel made contact with Mr F's two sons. Steps were also taken to identify and contact friends of both Mrs J and Mr F, and this has yielded some information from statements and interviews. Further details of the approach to involving those who knew Mrs J or Mr F are given in Appendix C. The Panel appreciates these contributions but recognises that it has had limited success in finding contacts who might represent Mrs J's viewpoint. Where references

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[3] Relate did not offer comment on the particulars of this case.

are made to the friends in this report they draw from these sources, but do not claim to be the views of all those concerned.

Review Panel

21. The Domestic Homicide Review Panel members were as shown in Table 1. The Panel held four face to face meetings between 12th April 2017 and 24th January 2018 date, and conferred by electronic means to clarify evidence and finalise details of the report.

Table 1: membership of the Review Panel

Agency	Panel member	Job title
n/a		
Devon and Cornwall Police		Serious Case Review Team
Devon County Council		
Devon Partnership Trust		Practice Lead: Safety and Risk
East Devon District Council		
NEW Devon Clinical Commissioning Group		Lead Nurse, Adult Safeguarding[4]
Royal Devon & Exeter NHS Foundation Trust		
Splitz Support Service		Service Manager, Devon

22. No members of the Panel had any prior direct involvement with the events or decisions covered by the review, or management responsibility for any staff whose actions are described. The Review Panel operated collaboratively to reach agreed conclusions. This report and recommendations are agreed by the whole Panel and signed off by the Chairs of Safer Devon Partnership and East and Mid Devon Community Safety Partnership. The report has been approved by the Home Office appointed national Quality Assurance Panel for domestic homicide reviews, and includes some amendments suggested by that Panel. The letter from the Home Office is shown in Appendix E.

[4] Until December 2017, when he left the post. The Clinical Commissioning Group did not nominate a replacement.

23. The Independent Chair, who was also the author of the report, has never been employed by any of the agencies concerned with this review, and has no personal connection to any of the people involved in the case. Further details of her relevant experience are given in Appendix D. The Panel had administrative support from the Safer Devon Partnership Domestic Homicide Review Co-ordinator, based at Devon County Council.

Parallel Reviews

24. As explained above, the Review followed the inquest into the death of Mrs J, and ran in parallel with preparations for the inquest into the later death of Mr F. So far as the Panel is aware no other reviews into the death of Mrs J have taken place or are planned.

Equality and diversity

25. The Panel has considered the relevance of the nine protected characteristics under the Equality Act 2010 in setting the terms of reference and conducting the Review. Noting that both Mrs J and Mr F were aged over 65, the report comments on whether their age may have had an impact on their access to or experience of services. Mrs J suffered some limitations of mobility through health problems, and the Panel has considered the implications of this. Their marital status (engaged after both being widowed) has been considered in attempting to understand how they saw their situation and future options.

The homicide

26. The homicide took place in a field owned by Mr F, a few miles from House M. Later that day Mr F went into a main police station and reported that he had attacked her. This account of the killing is based on his police interview and consistent with forensic evidence.

27. As was their custom, Mrs J had accompanied Mr F on his middle of the day visit to the field to feed cattle he kept there. Sitting in the car, they argued over Christmas arrangements. Mr F felt she wanted to exclude his younger son (Son B) and was making him choose between his son and her. He said Mrs J turned the argument to his lack of attention to her and both started to use abusive language. He described being in an uncontrollable state of mind, a shaking frenzy. He got out of the car walked around to the passenger side. Mrs J had also got out of the car. As they continued to argue, he said she started hitting him with her hands - although without causing any visible injury.

28. Mr F took a piece of metal pipe (related to his business) from the back of the car and returned to Mrs J and, while facing her, hit her in the back of the head with it. He told police that when he got the pipe his intention was to hit her and

kill her. She immediately collapsed to the floor and made no further sound or movement. Mr F returned to his vehicle boot and retrieved some nylon rope and strangled Mrs J for about a minute. He told police that he was unsure what damage he had done to Mrs J with the pipe and strangled her to make sure she was dead. Mr F then dragged Mrs J's body to a van he used as storage in the field. He returned to House M to change his clothes, putting them all in a bag but not disposing of them, before driving to a police station to admit the crime.

29. Mr F told police that there had been no previous violence from either party, and that Mrs J had walked out of the house during arguments but had not gone far and returned. He stated that the only difference he could identify (in the argument prior to the homicide) was that he had "had enough". The post mortem and inquest found the cause of death to be the combined effects of blunt force head injury and compression of the neck by ligature. The Coroner, noting Mr F's confession to the police, returned a verdict of unlawful killing.

Chronology

Earlier history of the relationship

30. Mrs J and Mr F first met in 1978, as neighbours in Devon. He was then married to Mrs F, and they had two young sons. In March 1982, when she was 37, Mrs J married Mr J, both having had previous marriages dissolved. Both Mr J and Mrs J worked in retailing, for different employers.

31. The two couples became friends, keeping in touch after Mr & Mrs F moved to House M in 1985 and Mr & Mrs J later moved to another part of Devon. Following Mr J's retirement, he and Mrs J spent a few years travelling then settled in Wiltshire. Mr J suffered from dementia in later life. Contact between Mrs J and Mr & Mrs F increased after Mr J's death in 2008. Mrs J's neighbour in Wiltshire recalls Mr & Mrs F visiting about three times a year.

32. After the death of her husband, Mrs J increased her involvement in the social life of the park home estate where she lived, going with women friends to activities such as sewing and games groups, and lunches at local garden centres. Friends there recall her as a lovely person, but private about personal matters.

33. Mr F, an agricultural engineer, was made redundant by his long term employer around 2000, and subsequently set up his own business, which his elder son (Son A) joined in 2013. He also owned some farmland on which he kept cattle. Friends recall him as gentle and polite.

34. Mrs F died in November 2013 from cancer, having been in poor health for several years.

Developments in 2014-2015

35. Friends recall Mrs J's friendship as having been mainly with Mrs F up to this point. During 2014 Mr F and Mrs J kept in touch by phone, and in the autumn of 2014 he started to visit her, and then to take her back to Devon for weekends. They confided few details of the growing relationship to friends, so the timing is uncertain. However, Mrs J did tell a mutual friend in 2014 that she was surprised that after only three visits Mr F had asked her to move in with him. No-one else lived at House M at this point. Son A visited frequently to collect business post and materials, and Mr F's younger son, Son B, then living in northern England, often came to stay.

36. Early in January 2015 the couple told friends and Mr F's family that they had become engaged. The speed at which the relationship had progressed caused surprise. Mrs J started living with Mr F in House M in mid-January, bringing down some personal possessions. In February she put her park home on the market, and it sold in June. She last saw her Wiltshire friends when she and Mr F came up in late June or July to clear the property. Their mood appeared good. However, the relationship had in fact already started to deteriorate.

37. The picture of the course of the relationship that emerges from police interviews with Mr F after the homicide, statements then taken from his family, from her friends in Wiltshire, and from friends and neighbours in Town N, is consistent. Some elements were reported by Mrs J to her friends, some by Mr F to his family or friends, and some were observed.

    a) Mrs J did not become integrated into Mr F's family, despite having known them since his sons were young, and having in the past had a relaxed relationship with them. Events arranged over the weekend of 31st January / 1st February 2015, which were intended as opportunities for her to meet them over meals out and activities, did not go well. She appeared reluctant to engage in conversation, and it proved hard to include her in activities, perhaps due to her health. Mr F's sons, particularly Son B, found that their father appeared awkward with them when Mrs J was present. Mr F's contact with Mrs F's parents, who lived nearby, became much less.

    b) The couple planned to sell House M and buy a new home together in the area. They found a suitable house near the fields owned by Mr F, and started, but did not proceed with, the purchase. This appears to have been due to Mr F's reluctance to go through with the move rather

than any other obstacle. Discussion of a potential move continued, but Mrs J recognised that Mr F was no longer keen on the idea.

c) Mrs J wanted to change aspects of House M, but found Mr F reluctant to agree to this and felt he wanted to keep it as it was when Mrs F was alive, even to the point of leaving an ashtray she had used untouched. However, some changes were made, including redecoration of the bedroom and bathroom, and changing some furniture.

d) There was tension between Mrs J and Son B and his girlfriend on their visits, over matters such as use of the television and access to the kitchen. In her presence, activities that Mr F enjoyed on earlier visits, such as playing board games, did not take place. In response, Son B continued to visit Devon but usually stayed elsewhere.

e) Mrs J does not appear to have joined any social activities in Town N of the sort she had enjoyed in Wiltshire. These would have been available nearby, as House M is within walking distance of the town centre. She was polite but unresponsive to female neighbours and friends of Mr F who tried to get to know her. While living in Wiltshire Mrs J kept in touch with a long-term friend from Town N through weekly phone calls. While these continued after she moved to House M, the friend was disappointed that they only had a few face to face meetings.

f) Mrs J wanted Mr F to spend more time with her than he did. She was disappointed that he continued to work virtually full time. However, she enjoyed accompanying him to his fields, watching him tend the cows and looking at wildlife together. They do not appear to have shared other interests outside the home. She told friends she was finding it hard to talk to him. They took a holiday together in Wales early in June 2015, which she said was to discuss things, but had arguments during it.

g) Mr F had been a keen bell ringer for many years, spending several evenings a week with bellringing groups as well as ringing at two churches on Sunday mornings. After Mrs J's arrival he continued this, though his family noticed some signs that she resented it. Mrs J had been accustomed in Wiltshire to socialising during the day but staying in during the evenings.

h) Mrs J discouraged Mr F from social contact with other women. Examples included persuading him to stop contacting one neighbour by text, and him telling another neighbour that she would be upset if she saw them walking into town together. She expected him to keep in touch with her by phone at set times so that she knew where he was. Her friend told police that "she seemed to be besotted with him, [Mr F]

seemed to be all she wanted and she wanted to be with him as often as she could". After the homicide Mr F told police that "She seems to think the only real couple in love is being in each other's faces".

i) The couple had many arguments. These had started by the time they took a holiday together in Wales in early June 2015, and the issues included his contact with other women, removal of items associated with Mrs F, and relationships with other family members. Mrs J told a friend that Mr F called her a "nag", while he told his son that she had said he was "not a real man".

j) Mr F told police (after the homicide) that he tried to find common ground and make suggestions as to how issues might be resolved but they never worked. He said he suggested going to Relate[5] but Mrs J refused, not wanting to have other people involved and thinking they could sort their differences between themselves.

38. Mrs J and Mr F kept their savings separate, but had set up a joint account into which her pensions were paid, and to which he contributed, from which the household bills were paid. At the time of her death Mrs J had funds from the sale of her park home in a savings account, and over £5000 in another savings account. Mr F held capital funds worth about twice as much as hers. Neither Mr F nor his family were beneficiaries of Mrs J's will.

39. Both Mr F and Mrs J had mobile phones. He used vehicles and computers in his business. She had access to a car registered in her name, and her GP confirmed that she was fit to drive. She owned a tablet computer and is known to have used it to play online games with friends.

40. By early autumn Mrs J had told friends that things were not going well and she realised they would not get married or move house. Although she was still wearing the engagement ring when she died, there is no indication that a date for the marriage was ever set. Similarly, Mr F had indicated his regrets at starting the relationship to several people. Mr F's sons recall him saying, after a meeting on 26th October 2015 with the solicitor who was handling Mrs F's estate, that he was trying to end the relationship but felt he could not do so while Mrs J was ill.

41. As described more fully below, Mrs J had day surgery for a gastric problem, and the stitches were still in place at the time of the homicide. However, she

[5] The local centre of the national federated charity Relate is Relate Exeter and District, a charity which aims to help "local people from all walks of life have happy relationships" through counselling. It runs bookable weekly sessions for initial assessment in a community building in Town N.

was making a normal recovery from this and her mobility at the time of the homicide was not restricted by it.

Contact with agencies

42. During the development and quality assurance of this report, an additional Appendix gave details, in chronological order, of the agency contacts summarised below. This assisted the Panel in reaching conclusions but is redacted from the published report as it was largely extracts from medical records.

Primary care and mental health services

43. Both Mr F and Mrs J received primary care services from Town N Surgery. It is a large practice, where patients are registered with named GPs who aim for continuity of contact. In the period of covered by the Review Mr F was registered with GP1 and Mrs J with GP2.

44. Over several decades, Mr F consulted GPs a number of times about family and work situations he found stressful. In summary these were:
    - In 1991 about his relationship with his wife and teenage sons. He spoke of being “dominated by” and “scared of” Mrs F;
    - In 1996 & 1997 about stress which he ascribed to unfair treatment at work;
    - In 2000 about feelings of worthlessness following redundancy: he was prescribed anti-depressants until 2002;
    - In 2000/2001 anxiety about his relationship with Mrs F: he was advised to seek help from Relate;
    - In 2008 about coping with a serious issue in the wider family;
    - In 2009, 2011 and 2013 about stress related to his relationship with Mrs F and her health problems, which he thought were more mental than physical. He sought access to information about her treatment that doctors could not give him without her consent.
    - One of the GPs who had treated Mrs F recalled that there was mention of “marital disharmony” in her notes, and that Mr F had not seemed empathetic during her terminal illness. However, this was not at a level of abuse or neglect.
    - In September 2013 a healthcare assistant at the Surgery completed a carer’s check with Mr F and noted that he “is unhappy but not depressed and has accepted that he is a carer even if he thinks he doesn't really need to be”.
    - In the last part of 2013 there were various contacts through Mrs F’s final hospital admissions and death.

45. In September 2014, on attending for routine monitoring of his blood pressure, Mr F talked to GP1 about his feelings following the death of Mrs F (the

previous November), which were complex but included relief and no longer "feeling like a doormat". He declined an offer of counselling, but agreed to a further appointment with GP1 to allow fuller exploration of these feelings. At this consultation, in October 2014, he expanded on pressures he had experienced in his marriage and family life. He did not, however, disclose that a new relationship was developing with a family friend. He agreed to GP1's plan to refer him to Devon Partnership Trust's Older People's Mental Health Team (OPMHT). In the referral, GP1 described Mr F as experiencing increasing symptoms of variable mood and fragmented sleep that had been present for several years but had increased following the death of his wife.

46. GP1 also asked Mr F to complete a questionnaire (a tool to assess depression) and return with it for a further blood pressure check. That occurred on 4th Nov 2014, and Mr F said he felt significantly brighter in himself and not low at all. He indicated he had lots of plans, but did not talk about Mrs J.

47. On 25th Nov 2014 Mr F was assessed at home by a Senior Mental Health Practitioner (SMHP1) from the Older People's Mental Health Team. In this he discussed emotional problems including adjustment to the death of Mrs F. He said their marriage had been "troubled" and referred to other tensions in the family. Although this was less than three months before he would announce his engagement to Mrs J, he did not mention any new relationship.

48. The assessment concluded that Mr F appeared to have been suffering from an adjustment disorder related to the death of his wife (Mrs F) and subsequent mixed feelings and guilt he had round these. SMHP1 discussed opportunities for him to explore his feelings in more depth by onward referral to the Depression and Anxiety Service (DAS) or psychology, but Mr F did not wish to pursue these avenues or consider medication options.

49. The conclusion of the assessment was that at that time there was no on-going role for secondary mental health services. SMHP1 explained this, and Mr F accepted the decision that the service would now discharge him. He was advised that the team would be happy to assess him again should he and / or his GP feel that necessary in the future. At the end of the assessment SMHP1 gave Mr F, as is standard practice, a courtesy card, which details the practitioner seen, telephone contact number and address.

50. Mr F next saw GP1 in June 2015, when he reported significant stress affecting his digestion. He ascribed this to buying a new home and a new relationship, and said he thought he might be depressed at times. This appointment did not result in any further action. A few weeks later, in July 2015, Mr F and Mrs J had a joint appointment with GP3, who was providing

sabbatical cover for GP2 that summer, disclosing strains in their relationship. This is described below (#56ff).

51. In November 2015, nearly a year after his meeting with SMHP1, Mr F telephoned him for advice, saying that he had found the Devon Partnership Trust courtesy card in his jacket pocket. He discussed his low mood and said he was experiencing relationship difficulties, but denied any suicidal ideation and did not divulge any intention of harm towards others. Given the limited past contact with the team, the length of time since that contact, and the absence of evidence of risk, SMHP1 judged that primary care would be the most appropriate pathway and so Mr F was advised to contact his GP again.

52. A couple of weeks later, on 24th Nov 2015, Mr F saw GP4[6]. She had not previously seen him as a patient, but had been Mrs F's GP. He explained that he had started a relationship with an old family friend. He said that Mrs J now referred to him as her "carer", and that he felt had taken on this role as she had mental health problems. He was in a low mood - clearly unhappy. GP4's perception was that he had come to a crossroads in the relationship and was trying to make a decision as to whether to continue with or leave it. Mr F did not express any thoughts of violence to anyone. GP4 did not ask whether he had any suicidal thoughts.

53. GP4 had a discussion with Mr F about counselling in general and about relationship counselling. She advised him to seek counselling from Relate as they would be able to mediate with Mrs J should he decide to end the relationship. Referring to the assessment by SMHP1 the previous year, she asked whether he now wanted to consider talking therapy or medication, but he was still not keen. He agreed to again take the patient health questionnaire (PHQ9) and bring it back at a further consultation, at which they could discuss medication. Her understanding was that he did intend to contact Relate in the meantime. She saw nothing in Mr F's demeanour to indicate he would be violent to anyone.

54. The PHQ9 form is a list of 9 questions, each with 4 answers, marked from 0 to 3, so 27 is the highest score: higher the score, the more depressed. GP4 anticipated that Mr F would return for a follow up appointment, with a high score, and that she could support him through further discussion and referral to other agencies if required. Following the homicide, Mr F told police that he had filled it in, got a score of 25, and considered himself severely depressed, and realised he should have made the return appointment.

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[6] It is not known whether Mr F asked to see GP4 rather than GP1 or whether this was the most convenient appointment.

55. Mrs J registered with Town N Surgery in February 2015. At her initial consultation with GP2 she showed an understanding of her physical health conditions and an organised approach to arranging continuity of secondary care after moving home. Her subsequent consultations related to physical health issues, with referral to and follow up from the hospital attendances described below. Her last visit to a GP was on 14th Aug 2015, when she saw a locum about symptoms which led to the gall bladder surgery she had in November.

56. A month before this, on 16th July, Mrs J and Mr F had attended Town N Surgery together and met GP3. The notes of this consultation were recorded in Mrs J's file but not Mr F's. They outlined their situation and Mr F said he was feeling under pressure to cope with Mrs J, as she had a lot of medical issues and he was still working. He felt she leant on him too much, and was struggling with her and thought of their future. At that point they were meant to be buying a bungalow together. Mrs J felt the issues were with Mr F and she had concerns about trusting him. He felt she overreacted and was a bit too needy of him, and that this was making him ill.

57. In discussion with the couple, GP3 tried to help them focus on dealing with the relationship issues, suggesting Relate as a source of help if they wanted to work out a way of continuing it. She encouraged Mr F to seek help on his own health from GP1 and gave him a leaflet about the depression and anxiety service, and Mrs J to consider asking to see a doctor on her own. GP3 noted the consultation as "slightly difficult" and recognised that it was "not an easy situation as she [Mrs J] has moved here".

58. It is not known which of the couple had initiated this consultation. There was an earlier attempt, in May 2015, by Mr F to talk to GP2 about Mrs J's health. He left a message asking her to phone him because he was concerned about Mrs J being depressed. GP2 returned the call and left a message inviting him to call again, but he did not.

59. There is no evidence that Mrs J had mental health problems. She had no contact with Devon Partnership Trust in recent years, and no record of mental health treatment outside Devon. However, back in 1984, at an early point in her marriage to Mr J, she had sessional contact with a psychology team for support with tension and anxiety.[7]

[7] Brief details of this are in Devon Partnership Trust records. Notes from this long ago are not retained.

Hospitals

60. Mrs J suffered from arthritis and had had, at various times before returning to Devon, joint replacement operations on her hips, shoulders and knees, and medical treatment for digestive problems. Although not disabled, she found some movements difficult and was significantly less physically fit and active than Mr F. On meeting her, some of Mr F's friends thought the age difference between them much greater than it was.

61. During 2015, Mrs J was treated by Royal Devon and Exeter for some moderately serious medical conditions, with two emergency admissions (March and June) resulting in inpatient treatment, planned day case surgery to remove her gall bladder in November, and outpatient attendances in June, July, and November. There is no reason to ascribe these medical conditions to domestic abuse.

62. A South Western Ambulance Services NHS Trust ambulance collected Mrs J from home for the emergency admissions. Training on recognition of domestic abuse is given to all the Trust's crews, and no concerning signs were seen.

63. On the first admission, but not in subsequent contacts, Royal Devon and Exeter staff asked the screening question "Do you ever feel frightened by your partner or other people at home?" and Mrs J said she did not. On her second inpatient admission, staff did not ask the question on admission paperwork about domestic abuse. Mrs J was admitted during the night and staff report that they do postpone lengthy questioning until the following morning, dependent on cause of admission. It is not clear whether staff were not advised the next morning that admission paperwork needed completing or forgot to complete it.

64. Patients attending for outpatients and day case admissions at Royal Devon and Exeter are only asked about domestic abuse if staff identify possible signs of this. It is not part of routine questions. Hospital notes show that Mr F attended Royal Devon and Exeter to collect Mrs J from day surgery and accompanied her to an outpatient appointment in November (her final contact with Royal Devon and Exeter). Nothing of concern about their relationship was noted.

65. Mr F was in reasonable physical health, with no referrals to hospital in the past ten years, but with hypertension monitored by blood tests in primary care. He was strongly built and kept himself fit.

Voluntary sector

66. Neither Mrs J nor Mr F sought support from voluntary sector advice agencies. Domestic abuse services in Devon had no contact from Mrs J, Mr F or his late

wife Mrs F. Nor did those in Wiltshire, where Mrs J had previously lived. The Devon branch of Relate confirmed that Mr F had not asked them for help. They were not known at the main community centre in Town N, which provides a range of drop in advice.

Overview

67. In summary, at the time of the homicide Mrs J had lived in Devon for just over 10 months, having moved from Wiltshire to join Mr F, who had lived in Town N for most of his life. They had known each other for over 30 years, but only formed a romantic relationship after both being widowed. This developed rapidly: within a few months they had announced their engagement, and Mrs J had sold her home and moved into Mr F's home, in which he had brought up his now adult sons with his late wife. She expected that they would buy a new home together but this did not happen, and the relationship became fraught.

68. Mrs J had several physical health problems, which led to a number of contacts with primary and secondary care during her brief residence in Devon. No domestic abuse was disclosed or observed in these. Mr F assisted her by calling ambulances or collecting her from hospital. While she was not dependent on his care, he worried that she might become so. He had found coping with Mrs F's final illness difficult.

69. Mr F was in good physical health but had attended Town N Surgery a number of times over the years with issues, in the family or at work, causing him stress or anxiety. In the two years between the deaths of his wife Mrs F and fiancée Mrs J he had six consultations with GPs in which he talked about past and present relationship difficulties. In the middle of this period he had an assessment from Devon Partnership Trust and was offered mental health treatment which he declined. In none of these contacts did Mr F show any sign that he might harm himself or others.

70. GPs also advised Mr F, and Mrs J on the one visit they made together, to seek help from Relate in talking through their future. Neither did, and Mr F told police that Mrs J thought they should sort things out without involving others. There is no indication of violence between them prior to the homicide, but they both used harsh words when they argued. There are examples, from a variety of people who knew them, of behaviour from Mrs J towards Mr F which could be regarded as controlling, but not of control by Mr F of Mrs J. Neither contacted any agency about domestic abuse.

Analysis

Nature of the relationship

71. The status of the relationship at the time of the homicide was ambiguous. While Mrs J continued to wear the engagement ring, no plans had been made for their wedding, and people who knew them, observing the tensions, no longer expected them to marry. GP4, the last professional to talk to Mr F, saw him as at a crossroads in deciding whether to end the relationship, and depressed at his situation. It is likely that Mrs J realised this, but there is no indication that she was ready to give up on the relationship and plan an alternative future. The couple had been living together in House M for about 11 months. This had been Mr F's family home for around 40 years. He owned a half share in it, and had a life interest in the remaining half under the terms of Mrs F's will, with ownership held in a trust in which he and his two sons were trustees. Mrs J retained the capital from the sale of her former home, but was aware that this was insufficient to buy a home of any sort in Town N. There is no indication that she made enquiries about returning to the park home site she had left in Wiltshire, but it is likely that this, even if possible, would have involved financial loss. However, a friend there had offered her a spare room, and she had access to savings sufficient for a short term rental in Devon while planning her future.

72. Mrs J's understanding on moving to Devon had been that she and Mr F would jointly choose and buy a new home in the area, but this plan soon fell through. It is understandable both that she wanted to shape a new home for their life together, and that he was reluctant to leave or significantly change the home he had lived in for so long. His mixed feelings about his late wife may have contributed to tensions over Mrs J's reasonable requests to remove items associated with her. Sensitivity about visits from adult sons, for whom this was a familiar family home, is normal for a new partner, but Mrs J does not seem to have drawn on her long acquaintance with the family to ease this.

73. It seems that Mr F started regretting his decision to invite Mrs J to live with him quite soon after her arrival. The increasing frequency of her health problems is likely to have added to his desire to see her gone, given the frustrations he expressed while supporting Mrs F through several years of illness before her death. However, he did not want to tell Mrs J to leave House M in the run up to Christmas while she was recovering from surgery, knowing that she had no other relatives to turn to. GP4, who saw Mr F shortly before the homicide, perceived him as trying to reach a decision as to whether or not to end the relationship. It would have been his first experience of doing this in many decades.

74. The uncomfortable situation Mrs J found herself in was a result of mismatched expectations, and did not constitute domestic abuse by Mr F. There are no indications that he was physically abusive to her, or neglected her welfare, before the homicide. His suggestions to her GP that she was mentally ill do not appear manipulative, but more an expression of his own distress. Nor are there indications that he attempted to control her movement, communications or finances. Both appear to have been verbally abusive during arguments.

75. While Mrs J was less fit and mobile than Mr F, she was able leave the house without assistance, walk and drive. They lived close to the centre of Town N, which has reasonable amenities and public transport. She had access to a car and the internet. She kept her own bank accounts and was in touch with friends by telephone on a weekly basis.

76. Mrs J showed some low level controlling behaviour towards Mr F. While the boundary between control and a reasonable expectation that a new partner will adapt their routines is hard to draw, some of her actions crossed it. These included urging him to end friendships with other women, and to phone her from work at set times of day. Mr F described her as untrusting, and her actions may have been attempts to get reassurance that he valued her. He indicated to others that he felt she was trying to control him. He told a GP she spoke of him as her "carer", although she did not in fact need personal care.

77. It is not possible to say whether other aspects of Mrs J's behaviour were part of a pattern of control, or within the norm for establishing a new relationship. Her arrival inevitably changed the way in which Mr F spent time with his sons and their families, but she seemed to them unwilling to co-operate with attempts to include her. Mr F probably knew that her late husband Mr J lost contact with his children after their marriage, adding to the concern this caused. However there had been stresses within Mr F's family before Mrs J's arrival.

78. Mrs J wanted Mr F to spend less time on his work and hobbies, and more with her. Having left familiar surroundings to live with him, she had reason to expect this to some degree. She did not take up opportunities to develop her own friendships and interests in Town N, but ill health could have limited her energy or inclination to do this.

79. There is no indication that Mrs J was violent towards Mr F, or sought to control his money other than by checking entries on their joint household account. They had heated arguments, which included insults, but there is no evidence of an imbalance of power in these that forced Mr F into actions against his will. Doctors observed that Mr F struggled to explain himself when distressed or frustrated, and police recalled similar difficulties when he described the killing. This fits with Mrs J telling friends that she was finding it

hard to talk to him. Mrs J may have been more articulate, but may also have found it difficult to talk about personal matters.

Cause of the homicide

80. Conclusions about what led to the homicide must be qualified by the fact that the evidence has not been tested through a criminal trial. However, the description given to police by Mr F is plausible: of him taking up nearby tools as weapons to kill Mrs J during a heated argument which she had at least an equal part in starting. She is known to have enjoyed their regular trips to the field, so there is no reason to think he coerced her to be there. An argument about arrangements for including Son B at Christmas is consistent with what others have said about the nature of their quarrels. As an engineer and cattle tender, Mr F was accustomed to wielding tools effectively and decisively, so it is not surprising that, having taken them up as weapons with intent to kill, he used them in the manner he did. Mrs J stood no chance of defending herself against the assault.

81. It seems very unlikely that the homicide was pre-meditated. While Mr F clearly wanted Mrs J out of the way, he was never heard to threaten her. With access to land and tools, and no-one else in daily contact with her, he had the means to stage an accident or disappearance with a good chance of escaping the blame. Some of his actions after the killing suggest he might have considered concealing the crime, but they are also consistent with his taking time to absorb the shock and clean himself while protecting the body from cattle. He soon reported the assault to police and handed himself in, appearing to them as a quiet man shocked by what he had done.

82. The homicide thus seems to have been unplanned but deliberate violence in the context of a quarrel between a deeply unhappy man and a woman, who had thrown her lot in with him, whose expectations he felt unable to meet.

Role of agencies

Devon Partnership NHS Trust

83. Following a routine referral by his GP in October 2014, the Older People’s Mental Health Community Team saw Mr F for assessment within their target time (despite him being unable to take up the first appointment offered). Mr F was seen at home, as was appropriate, with Son A present (by coincidence rather than intent) towards the end of the session. The assessment identified problems Mr F was having in adjusting to the death of his wife (Mrs F) the previous year, and his mixed feelings about this, arising from a troubled relationship.

84. Mr F was offered support with these issues both through referral to Devon Partnership Trust services in which he could have talked about his feelings in more depth, and through medication. As he did not wish to follow either of these paths, and at the time of the assessment his mood was normal with no suicidal intention or psychosis, he was discharged. He appeared content with this, with the assurance that he could ask for a future assessment if required.

85. The November 2014 assessment did not present an opportunity to identify that Mrs J was at risk. Mr F did not disclose to SMHP1 whether he was in, or contemplating, another relationship. It seems likely that by this time his friendship with Mrs J had intensified, even if he was not already contemplating inviting her into his home. In talking about his late wife, he did not disclose any actual violence or desire to harm her, but did say that he had contemplated divorce a few years before her death, though he felt he had to stay due to her ill health.

86. Devon Partnership Trust did not at the time have a programme for training clinical staff in identifying or responding to domestic abuse, but introduced one in 2017. Nothing which Mr F said in the November 2014 mental health assessment would have triggered a domestic abuse risk assessment, even if he had been prompted to disclose that he was starting a new relationship. However, he might, if he had revealed it, have been advised by SMHP1 to consider how he would access help if that, too, proved problematic.

87. When Mr F telephoned SMHP1 in November 2015, using the contact details left at the original assessment, he was seeking advice and appeared to understand that he was no longer on the caseload. He described a drop in mood and some relationship difficulty, although this was not discussed in any detail during the telephone conversation. While he did not reveal this, the call was made in a month in which Mrs J had attended hospital three times. SMHP1 did not consider the short conversation he had with Mr F to indicate any concerns or significant clinical risk. There was no evidence of suicidal ideation, or threats to others. There had been no history of concern in relation to harm to self or others and Mr F seemed happy with the advice he was given to contact his GP in the first instance.

88. Given the lack of any signs of imminent risk or concerns, SMHP1 acted correctly by re-directing Mr F to his GP. The Older People's Mental Health Community Team cannot accept direct referrals from individuals, but takes referrals from GPs, and other Devon Partnership Trust teams such as Crisis Resolution Teams, and Psychiatric Inpatient Services.

89. If during the telephone call Mr F had indicated a mental decline or had volunteered that he was going to imminently harm himself or anyone else then the staff member taking the call would have made a clinical judgement on an

appropriate response based on the level of risk / urgency. A high / immediate risk would get a same day response through a home visit by two practitioners to fully assess mental state and current risk, with further action including hospital admission and Mental Health Act assessment as options if required.

90. SMHP1 did not originally record the telephone call in the clinical record as the call was considered to be 'signposting'. Following the homicide and team manager's review retrospective account of the conversation was written up in the notes by SMHP1. The lesson has been drawn by him and the wider team about timely and appropriate updating of clinical records when such contacts occur no matter how short they may be.

Royal Devon & Exeter NHS Trust

91. Inpatient admission paperwork prompts staff to ask questions about domestic abuse. In this case, the correct process was undertaken on one inpatient admission, while the other later inpatient admission could be seen as a missed opportunity. On initial admission to Emergency Department in March 2015 Mrs J was asked about domestic abuse and answered "No" to the questions relating to whether she was feeling frightened at home. This was good practice, as advised in training and in the Trust domestic abuse policy.

92. On the June admission as an inpatient to the Royal Devon & Exeter Hospital, the question about domestic abuse on admission paperwork was not asked, and other questions relating to social history were left blank. The question about domestic abuse is marked "Domestic abuse – only discuss with the patient when they are on their own". It is not known if Mrs J was on her own on admission but it was late with admission to the ward timed at 00:55. In 2015 only staff who worked in the Emergency Department and the Centre for Women's Health were offered domestic abuse training. The Trust is now rolling out training to all clinical staff. However, there is no indication from any other source that Mrs J did feel frightened at home at that time, so it was not a missed opportunity to prevent her death.

93. At the November 2015 day case admission no questions were asked about domestic abuse: staff are not prompted to ask the question on the day case paperwork. However, the staff who treated Mrs J and saw her depart with Mr F did not recall anything in their manner that might have warned of the homicide, which occurred two weeks later. As part of the learning from this and another domestic homicide review, the Trust is reviewing day case admission paperwork and ensuring staff in all areas of day case work are trained to be aware of anything unusual that might indicate domestic abuse.

94. There were domestic abuse leaflets in the pre-surgery outpatients' department, though it is not possible to determine whether these were there at the time of Mrs J's attendance. While there are domestic abuse advice

stickers giving a contact number for local services on the inside of the toilet doors in most other toilets in the hospital there were none in the pre-surgery outpatients' clinic when a check was made for this Review. Action has since been taken by the Trust's Safeguarding team to promote wider use of the stickers. As these toilets are unisex and used by both patients and visitors, this was a possible opportunity for Mr F to have been alerted to a source of advice. While it is not known whether he accompanied Mrs J to the pre-surgery outpatient appointment in November 2015, her notes record that he did collect her from the day case unit and accompany her to an outpatient appointment for spinal pain later that month.

Primary care

95. Town N Surgery was an important source of support for both Mrs J and Mr F. The arrangement of a named GP was generally beneficial in providing continuity of contact with someone familiar with them. This may have helped Mr F be open about his feelings, and Mrs J to arrange transfer of her health care from Wiltshire. However, Mr F found it frustrating when he wanted to talk, in the same visit, about his wife or partner's health and the impact on him. While GPs did talk to each other about issues raised, there were points at which they seem to have lacked the whole picture of the household and strains within it, for example in the omission of the joint visit from Mr F's notes.

96. It is commendable that Town N Surgery provided a context in which Mr F felt able to attend to talk about his mental health and relationships. He did, however, find it hard to express himself directly when in low mood, with several consultations noted as "difficult". GPs recalled finding his line of thought hard to follow, wandering or circular. While doctors listened and suggested sensible actions, he seems to have been looking for help that they were not best placed to give: a way of dealing with a problematic new relationship in the shadow of a troubled past one.

97. The primary care response to Mr F's concerns – referral to the Older People's Mental Health Team and advice to contact Relate – was appropriate to the information they had, although with hindsight the offer of re-referral to the Older People's Mental Health Team could have been made in July 2015 rather than November. While it is not possible to know how far his feelings of depression arose from, or contributed to, the strains in his relationship with Mrs J, he might then have been ready to access the depression and anxiety service and explore this. By November Mr F himself contacted the Older People's Mental Health Team again, and though he did follow their signposting and go back to see a GP, by that time Mrs J had even more health problems and tensions over Christmas plans had emerged.

98. GPs advised contacting Relate as the way for the couple to understand and resolve a way forward for their relationship. While this was appropriate in the circumstances, they could have given more explicit attention to the potential for domestic abuse. The fact that Mr F had described his late wife as controlling (and she had spoken of marital disharmony), and that Mrs J had left her familiar surroundings to be with him, could have prompted further questioning of the degree of risk. However, it seems unlikely that this would have identified further concerns. While aware of and co-operating with local domestic abuse services, the practice did not have an overall policy or training programme.

99. While Mr F was willing to talk about his feelings and concerns to GPs at Town N surgery, he appears to have been unable to face the next step of arranging fuller counselling or advice. The GPs he saw did give him attention, but rightly judged that he would benefit from a specialist service with time to help him understand and reach decisions about his relationship. The relative ease of communication with Mr F recorded by SMHP1 confirms this. The referral to the Older People's Mental Health Team was useful, but, with hindsight, occurred at the time when Mr F was probably at his most positive. This may have been one of the reasons he declined further Devon Partnership Trust services.

Advice services

100. There were local services available which could have helped Mr F if he had seen himself as in an abusive relationship. In 2015 services in East Devon were provided through Exeter based Splitz Support Service, which includes a telephone helpline and one to one support and accepts self-referral from both women and men. In the year to April 2017, 39 of their new clients were aged over 60, and 7 of these were men. If Mr F had phoned Splitz in the month or so before the homicide he would have been given advice, but the level of risk would have been assessed as standard, and not justifying a full service.

101. Over a number of years the East and Mid Devon Community Safety Partnership has tried to raise awareness of domestic abuse in a variety of ways across the district of East Devon. In November 2014 updated leaflets and posters including helpline details were sent to outlets including all GP practices requesting that they be made available to both staff and members of the public. However, the imagery and examples used in such publicity do not identify older men as potential victims.

102. Mr F was willing to try relationship counselling through the voluntary agency Relate, as suggested by the GPs. However, Mrs J saw this as intrusion on a private relationship and refused the offer. Relate Exeter and

District provides counselling in Town N, managed from Exeter. Their website is clear that counselling for individuals is available without their partner needing to participate, (although this is required for mediation), and that advice on safely ending as well as continuing relationships is available. It is likely that an initial assessment would have identified that counselling of the sort offered could have helped either or both. There were no access or financial barriers to them seeking an assessment. Relate centres work to national policies and processes which include identification of clients who may be experiencing domestic abuse and referral on to other agencies where appropriate. These include recognition of situations where counselling is not a safe option.

103. Mr F had access to legal advice on the implications of his situation. He and his sons had engaged a solicitor in Town N to assist in handling the late Mrs F's estate, and visited their office in October 2015. It seems likely that the solicitor was aware that Mrs J was living in House M (half of which was held in trust as part of the estate), and had by that time alerted Mr F to the risk of her acquiring rights of residence in it.

104. East Devon District Council has a housing advice service to help people at risk of becoming homeless. In the hypothetical situation that Mr F had told Mrs J to leave House M and she had approached the Council for advice, they would have recognised her as homeless, and at extra risk due to her age, and tried to find emergency accommodation for her. She would probably have been required to pay for this as she had the means to do so. They would also have helped her to find more permanent accommodation in the private sector. As she had the means to pay rent (from her capital), she would not have been eligible for benefits but would still have been given advice and support.

Conclusions

105. This tragedy is at heart a search for love in later life which went wrong, with two widowed people, seeking renewed hope together, making choices which proved fatal for both. Their relationship progressed from a long term acquaintance to engagement and living together at a rate which surprised those who knew them. While they had shared memories of Mrs F, it is unlikely that Mrs J knew of the marriage problems Mr F had described to his GP, or that he was fully aware of her state of health. They had mismatched expectations, and had not found a way to resolve the resulting strains.

106. Mrs J responded with jealousy and attempts at control, refusing Mr F's suggestion of seeking counselling or mediation. Such help could perhaps

have enabled them to address not only their current conflict but the influence of past marriages on their hopes and fears.

107. Mr F tried to hold on to his previous pattern of life, resenting Mrs J’s demands, but not reaching the point of ending the relationship. Her ill health and limited options for finding an alternative home both constrained and frustrated him. The homicide was an extreme response in the context of an argument that was otherwise typical of many earlier ones. Killing is the ultimate form of domestic abuse, but there is no indication that this was an escalation of previous abuse in any form.

108. Mr F sought and received advice from health services in dealing with anxiety and depression. He had done this several times in the past when he felt stress in the family or workplace. In 2014 and 2015 he ascribed his problems as relationship difficulties - in his marriage and later with Mrs J - but gave no indication of intention to harm others or himself. He declined the offer of medication and of psychological therapies. His attention was drawn to a voluntary agency offering relationship advice, but he did not get as far as seeking it. It seems likely that his feelings of despair at his situation contributed to the homicide, but there is no evidence that clinicians missed signs of risk, or that their diagnosis was wrong.

109. Mrs J had several episodes of health care for physical conditions during her time in Devon. During some of these she had the opportunity to raise concerns about her safety at home, and staff were trained to look out for signs of domestic abuse. There is no indication that she felt herself at risk or that staff attending her missed any warning of the homicide.

Lessons to be learned

110. This tragedy illustrates that the health and wellbeing of older people includes healthy relationships. It has contributed to increased recognition, both within Devon and nationally, that domestic abuse is as much a risk for older people as for younger adults, despite their omission from some standard statistical sources. This is important in Devon, where 25% of people are aged 65 or over (30% in East Devon), compared to 18% in England overall[8]. Safer Devon Partnership has, through the Devon Domestic and Sexual Violence and Abuse Alliance (DDSVAA) given increased focus to raising awareness of this among professionals and the public, but recognises that there is more to do in changing perceptions. East and Mid Devon Community Safety Partnership has, since this tragedy, funded advertising on till receipts at main Argos stores, including the one in Town N, to publicize domestic and sexual

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[8] Office for National Statistics mid year population estimates 2016.

violence and abuse services, thus making the phone numbers discreetly available on an item anyone might retain[9].

111. The story also illustrates the importance of health services as a point of contact with older people, reaching many who do not need social care or housing services. Town N Surgery has made some use of materials to raise public awareness of domestic and sexual violence and abuse supplied by East & Mid Devon Community Safety Partnership, with slides on the waiting room TV presentation, and leaflets in the toilet lobby, though no posters on display when visited. The practice recognises that it has a relatively high proportion of elderly couples on its lists, and would be well placed to pilot ways of reaching this age group.

112. Devon County Council, working with Torbay Council and a number of other partners, has been successful in obtaining funding from the government Violence Against Women and Girls fund. This funding is being used to pilot a programme in 2018, working with the national IRIS[10] (identification and referral to improve safety) scheme, at GP practices in three localities Devon and Torbay. IRIS is a general practice-based domestic violence and abuse training support and referral programme. An Advocate Educator is linked to general practices and based in a local specialist DVA service and co-delivers the training to practices with a local clinical lead. Core areas are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. The project is aimed at women aged 16 and over who are experiencing violence or abuse from a current partner, ex-partner or adult family member, and women aged 18 years and over who are affected by historic childhood sexual abuse and / or recent or historic rape or sexual assault. This project will also provide information and signposting for men who are affected by sexual violence as well as for male victims and for perpetrators of domestic violence and abuse. While not targeted at older people, it has the potential to increase recognition of older victims, given Devon's higher than average proportion of older people in the population.

113. Royal Devon and Exeter is well advanced in its programme of training all staff in recognising indications of domestic abuse and knowing when to ask about it. Within this it is now raising awareness about how to help older people in Devon to recognise domestic abuse and seek or signpost appropriate support.

114. Devon Partnership Trust, while offering timely mental health support in this case, had not at the time developed a training programme on domestic

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[9] This joint initiative with Exeter Community Safety Partnership covered four stores over 14 weeks in late 2017 including the Christmas period, thus reaching several thousand customers.
[10] http://www.irisdomesticviolence.org.uk/iris/about-iris/iris-service/

abuse to ensure its staff are able to play an equivalent role. It now includes training on domestic abuse, including its nature and impact of domestic abuse, and responses including risk assessment and the role of other agencies, within a two day safeguarding course which is mandatory for clinical staff at band 5 and above. This includes the post held by SMHP1, which is important as Older People's Mental Health Team has a role particularly relevant to older people in mental distress arising from their relationships. Since January 2017 over 800 Devon Partnership Trust clinicians have been trained, and the Trust aims for 95% compliance by October 2018.

115. There was accessible professional advice available to both Mrs J and Mr F on domestic abuse and housing. While they did not approach these, Mr F did, with encouragement from GPs at Town N Surgery, try to persuade Mrs J to seek joint help from Relate, which could probably have helped them through the impasse they had reached. He also recognised his own mental distress and turned to primary care and mental health services for assistance. This is positive in view of the nationally recognised challenge of encouraging men to talk about relationship problems.

116. While the referral to Devon Partnership Trust was made by the GP, and Devon Partnership Trust then contacted Mr F to agree an appointment, the advice to contact Relate required Mr F to take the initiative. Relate do accept referral for assessment from professionals, but still want the potential client to make contact to arrange it, to show they are willing to engage. Mr F might have found it easier if the Surgery could have facilitated such contact – for example having a support worker able to help him make an initial call before he went home. A 2015 report[11] by Citizens Advice pointed out that 19% of GP consultation time in England (and rising) was taken up with non-health issues, with personal relationships the most common, and identified the potential for more efficient use of NHS resources if these needs could be met in a more effective way.

117. The information which Mr F disclosed to GPs did not indicate that he was experiencing or at risk of committing domestic abuse, but Splitz judge that, if he had given him the full picture, they could have given him support. However, as one GP pointed out, Mr F might have been even more reluctant to approach an unfamiliar agency about "domestic abuse" than about general relationship issues. This was not a term he had used in talking about either Mrs F and Mrs J, whereas he had used words such as "doormat", "needy", and "nag". Little attention has yet been given to presenting the services

[11] "A Very General Practice" Citizens Advice May 2015

available in ways that older men and women can understand and match to their own experience.

118. The available facts point to this homicide being the dramatically violent end of a relationship in which there had been little or no abusive behaviour by either party, or violence to others. The Panel recognises that this is unusual among domestic homicides, but thinks it important that this is recognised as something that can happen.

Recommendations

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

R1 Promote awareness among older people in Devon of the availability of local advice and support with relationship problems, including domestic abuse. (#110, 116, 117)

R2 Identify and share good practice in primary care settings in connecting patients who report relationship concerns or domestic abuse with appropriate sources of support. (#111,112)

R3 (National) In future national analysis of domestic homicide review reports, check the prevalence of domestic homicides in which no evidence of prior domestic abuse (fitting the proposed statutory definition[12]) can be found after the event. (#118)

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[12] Government consultation "Transforming the Response to Domestic Abuse" March 2018)

Appendix A: Safer Devon Partnership oversight of Domestic Homicide Reviews

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

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

- Devon County Council
  - Chief Officer for Communities, Public Health, Environment and Prosperity
  - Elected Member with responsibility for Community Safety
  - Principal Communities and Commissioning Manager (with responsibility for Domestic and Sexual Violence and Abuse)
  - Safer Devon Partnership Manager
  - Principal Social Worker, Devon Safeguarding Adults Board

- Devon & Cornwall Police
  - Detective Chief Inspector for Local Investigations (Devon) and SODAIT
  - Detective Sergeant from Serious Case Review Team

- North, East and West Devon Clinical Commissioning Group (NEW Devon CCG) and South Devon and Torbay Clinical Commissioning Group
  - Lead Nurse, Safeguarding Adults

- Devon Partnership Trust
  - Managing Partner, Safeguarding

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

- Members of East and Mid Devon Community Safety Partnership, via its Chair.
- Chief Executive and officer with responsibility for domestic homicide reviews (in this case the Anti-Social Behaviour and Community Safety Coordinator) of East Devon District Council
- Members of the Safer Devon Partnership Board
- Safer Devon Partnership's domestic homicide review Executive Group

- Chair of the DSVA[13] Strategy Oversight Group (which has responsibility for the DSVA Strategy and Action Plan and is accountable to the Safer Devon Partnership).
    - Comprised of senior managers, the group is responsible for leading and supporting a coordinated response to DSVA in Devon, through the strategic coordination of commissioning of DSVA services, partnership working and receiving assurances that effective and appropriate organisational responses are in place. Any work, projects or commissioning activity conducted on DSVA will be overseen, agreed and informed by the DSVA Strategy and Delivery Group
- Safer Devon Partnership Manager (who has responsibility for the management and co-ordination of domestic homicide reviews)
- Chair of the Devon Safeguarding Adults Board
- Chair of the Devon Safeguarding Adults Review Group
- Chair of the Devon Children and Families Partnership (Devon's Local Safeguarding Children's Board) and the Chair of its Serious Case Review Subgroup.
- Police and Crime Commissioner for Devon, Cornwall and the Isles of Scilly
- Town N Surgery
- Mr F's sons.

[13] Domestic and Sexual Violence and Abuse

Appendix B: Individual Management Reviews

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

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

AGENCY	IMR WRITER	INDEPENDENCE	STAFF INTERVIEWED	OTHER SOURCES
Devon Partnership Trust	Practise Lead for Patient Experience Safety & Risk	The author has not been involved with either the victim or perpetrator and has no line management responsibility for the clinicians involved within this case.	No	Clinical records for Mr F. Operational policy for OPMH team. DPT internal meeting note following notification of the homicide.
Royal Devon & Exeter NHS Foundation Trust	Senior Safeguarding Nurse Specialist	The author has not been involved with either the victim or perpetrator and has no line management responsibility for the clinicians involved within this case.	Sister who conducted Mrs J's pre surgery day case admission on Staff Nurse who cared for Mrs J pre and post-surgery on Staff Nurse who admitted Mrs J to the ward	Hospital notes including admission paperwork and correspondence. Electronic records of Emergency Department and other hospital systems

Appendix C: Involvement of family, friends and support networks

As explained in the Introduction (#19,20), Mrs J had no living relatives. Her executor was Ms Z, a friend made during her time living in Wiltshire, with whom she continued to speak on the phone at least once a week after moving to Devon.

The Safer Devon Partnership Domestic Homicide Review Co-ordinator briefly met Ms Z at the inquest into Mrs J's death and explained that there would be further contact about a domestic homicide review. Ms Z did not respond to subsequent contact by post or phone, but the Police evidence to the domestic homicide review has drawn on information she provided to the criminal investigation. The views of another friend of Mrs J from Wiltshire were obtained from the inquest, but she did not take up the invitation to further involvement.

Contact was also made with a resident of Town N who had remained friends with both Mrs J since they had originally met there, and had met Mr F through Mr J's funeral, but she did not want to add any comment on the tragedy beyond her original statement to police.

Mr F's sons both agreed to the Panel seeing the statements they had made to police after the homicide, but did not take up the offer to contribute further views.

A neighbour living near House M who had provided evidence to the criminal investigation agreed to meet the Independent Chair and Domestic Homicide Review Co-ordinator, giving examples of conversations with Mr F before and after Mrs J moved down, and also useful insights into on how a newcomer to Town N might find information about services. This meeting was recorded, with consent. Invitations to contribute was made to two other local contacts, but these were not taken up.

All those contacted were given information about the purpose of the Review and offered a choice of methods of contributing their views.

Appendix D: Independent Chair / Report Author

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

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

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

Appendix E: Home Office Quality Assurance Letter

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Julie Richards
Safer Devon Partnership Manager
Communities Team
Devon County Council
Room G60
County Hall
Topsham Road
Exeter EX2 4QD

22 November 2018

Dear Julie,

Thank you for submitting the Domestic Homicide Review (DHR) report for Devon (C8) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 26 September. I am sorry for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded that this is a well-written, clearly structured report with good exploration around, for example, the perpetrator's mental health. Despite limited agency contact, the review has undertaken robust analysis and identified well-argued, evidence-based lessons. The Panel particularly welcomed the practical action taken as a result of the review, such as the promotion of local services in outpatients' clinics with leaflets and stickers and advertising on till receipts issued by well-known High Street retail stores.

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

- Overall the review appears to be focused on the perpetrator's perspective and the Panel was concerned that some of the narrative, particularly around his relationship with his previous partner as well as his current partner, could be perceived as being overly sympathetic to him and, in turn, blaming the victim for some of the actions;

- There are statements and presumptions made in the report and the Panel felt the basis for these should be made clear. Examples include the victim not being ready to give up the perpetrator (page 21) and the conclusion that this was not an escalation of any form of previous abuse by the perpetrator (page 29);

- The Panel suggested the recommendations from the two IMRs should also be included within the overall actions indentified in the report;

- The Panel queried the need for the number of appendices and suggested information in appendices C and D could be included in the main body of the report. The Panel also recommended that the detail in Appendix E should be reviewed prior to publication;

- It is normal practice in these types of reviews to express condolences to those affected by the death;

- You may wish to remove the precise date of the murder mentioned a number of times in the report to enhance anonymity.

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

Yours sincerely

Hannah Buckley
Chair of the Home Office DHR Quality Assurance Panel