# Safer Somerset Partnership

# Domestic Homicide Overview Report

## Regarding Diane who died in February 2020



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**Independent Chair and Author**
**Updated January 2022**

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**The review panel would like to offer its condolences to the family and friends of Diane. It is our hope that this process will provide some answers to their questions. As a panel we were pleased to be able to include this pen picture of Diane, provided by her partner. These are his words. The only changes made were to protect confidentiality.**

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*I find it difficult to write about someone who I love dearly and meant so much to me. She brought such happiness and love to my home.*

*Many of her friends referred to her as the organiser, often bossy but always with a smile. Tiny in stature, size four shoes! But, the very biggest heart. Courageous and brave. Never afraid to tackle any project.*

*She faced into dealing with cancer with such determination. Vowing not to let it get the better of her. All through her treatment she continued with her daily life. Never complaining. She eventually conquered the dreaded breast cancer.*

*Coming to live with me was an immense challenge for her. Maybe daunting even.*

*Leaving her beloved home and all her friends behind was an incredibly difficult decision. However this challenge and decision was accepted, as it had to be done and faced head on with not the slightest hesitation. She knew that her new home had love, happiness and security. Something she had longed for over many, many years. My home was well known to her. She visited on many occasions over many years.*

*She had many interests but her lifelong love was her dogs. She built up an immense following for this rare breed and as a result increased their numbers substantially throughout the U.K. and beyond. Her father owned a gun shop in Sussex and it was from here that she gained great experience in the shooting field.*

*She also had a love of fishing. It was on Deeside, Scotland that I first was introduced to Diane over 25 years ago. Over the years we met annually with our group on Deeside and then Speyside.*

*My heart is broken as are many others. She was a unique, kind, loving, gentle, hard working lady. A replacement doesn't exist. I have a tree planted in my garden in her memory . I visit it every day.*

## 1. Introduction

1. This Domestic Homicide Review (DHR) Overview Report examines agency responses and support given to Diane, who has been a resident of Somerset, prior to her death in February 2020.

2. Diane's death was notified to Safer Somerset Partnership in March 2020. At the same time the death of her husband, from whom she had been estranged was also reported.

3. Diane had returned to Somerset from Ireland to meet friends and collect some personal belongings from the former marital home following the break up with her husband Jeremy. This included collecting two dogs. She had been living in Ireland for a short period, with her new partner. She arranged for her friend, to go to the house with her.

4. While at the house, having packed things in her car, Diane wanted to take the dogs for a short walk before the car journey. Jeremy went with her. Her friend reported that a few minutes later, Jeremy returned to the house, with a shotgun and said that he had shot Diane. Her friend, not initially believing this, asked Jeremy where Diane was, and he reportedly took her to show her Diane's body. Her friend reported to the DHR Chair that she identified that it was Diane, and that she had a gun shot wound. It was not clear to her if Diane was dead, and it is reported she died later, before the ambulance service arrived.

5. Jeremy then took Diane's friend back to the house and locked her in the stable block. She was able to see him and reported that she observed him attaching hosepipes to the car exhaust, which he was unable to do. Jeremy then returned to the locked stable to tell Diane's friend that he would now try to shoot himself. After five minutes he returned and was observed to saw off the barrels of the shotgun. He then went out of sight and she then reported hearing a muffled shot. She waited around 15 minutes and then managed to get out of the stable by prising a grille from the window. She then called the police.

6. A criminal investigation was initially commenced, as Jeremy did not die immediately but later succumbed to his injuries in hospital. An update on the status of the investigation has been provided to the DHR by the police and is as follows: "Given that the incident was self-contained with no other parties involved, and the main suspect is deceased, there can clearly be no

prosecution. Therefore the matter will proceed in due course to the Coroner to hold an inquest into their deaths".

Domestic Homicide Review

7. This DHR was commissioned because it meets the definition detailed in paragraph 12 of the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2016). The review has followed the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.

8. The police made the referral to the Safer Somerset Partnership (SSP) on the day after Diane's death. The SSP commissioned the DHR.

9. The purpose of the DHR to:

   - Establish what lessons can be learned from the domestic homicide regarding the way in which local professionals and organisations worked individually and together to safeguard the individuals who are the subjects of the review.

   - 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.

   - Apply the lessons to service responses including changes to policies and procedures as appropriate.

   - Contribute to the prevention of domestic violence and abuse homicide in the future, by using relevant findings to improve service responses for all subjects of domestic violence and abuse and their children through improved intra and inter-agency working.

10. The over-arching aim of a DHR is to increase safety for those who may experience potential and actual incidents of domestic abuse by learning lessons from the death in order to change future practice. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners and take action to make necessary changes.

## 2. Timescales

11. A tendering process was completed to appoint an independent chair and author and the formal contract was agreed in July 2020. The review formally commenced at that stage. A first panel meeting was held in September 2020, following a period of scoping and then Individual Management Review (IMR) completion and submission. The process was concluded in May 2021. The DHR panel met virtually four times, as well as additional discussions by teleconference. The Chair also held discussions by phone with the DHR lead within Safer Somerset Partnership.

12. The timescale for completion of the review was affected by the outbreak of COVID-19. As a result of the social distancing policy put in place in March 2020, it was not possible for the panel to meet in person. Despite this, the panel meetings were effective and conducted in accordance with the national guidance.

## 3. Confidentiality

13. The overview report and Executive Summary use the name Diane to denote the victim in this case and Jeremy to denote the perpetrator. It was taken to maintain confidentiality and in the absence of agreed pseudonym with the family. They could not decide on a pseudonym and invited the Chair to choose one on their behalf.

14. The review was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until the Safer Somerset Partnership accepts the Overview Report, Executive Summary and Action Plan and the Home Office Quality Assurance Panel have approved it.

## 4. Terms of Reference

15. Terms of Reference were developed and agreed. These were discussed by panel members, the independent chair and with family members. The Terms of Reference were as follows:

- Consider the period from 1 February 2015 to February 2020 (this is intended to cover the period from when the couple moved to Somerset) subject to any

significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.

- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004), and invite responses from any other relevant agencies or individuals identified through the process of the review.

- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.

- Aim to produce a report within six months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored

- To discover if all relevant civil or criminal interventions were considered and/or used.

- Determine if there were any barriers Diane or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.
    - In the context of the rural community in which Diane lived

- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse in rural locations such as where Diane lived.

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was

consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively?

16. This review is not an inquiry into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

## 5. Methodology

17. The decision to undertake the review was made by the Community Safety Partnership (CSP) having received information from the police about the nature of Diane and Jeremy's deaths and the CSP was satisfied that the case met the criteria for undertaking a review covering the three frameworks outlined previously.

18. A total of 15 local statutory and voluntary sector agencies were contacted as part of the initial scoping exercise by the CSP. Of those, 14 provided a response, with 9 confirming they'd no contact with either the perpetrator or victim, and the remaining 5 confirming some contact.

19. The DHR process was conducted in accordance with the national guidance. It including the receipt of Individual Management Reviews from relevant agencies, the production of a combined chronology and a series of panel meetings. The process also included significant engagement with friends of the couple and Diane's partner.

## 6. Involvement of family, friends, work colleagues, neighbours and wider community

20. The review sought to involve the family and friends of both the victim and the perpetrator in the review process. As a result of this, the Chair was able to speak with the friend of Diane, who was present at the time of the murder. The chair also spoke with 2 other close friends of the couple who had visited the couple and knew them well. The Chair also spoke with Diane's partner in Ireland. It was not possible to speak to other members of the family, who although contacted did not respond to the invitation to participate.

21. Family members whether participating or not were provided with the Home Office leaflets containing information about specialist advocacy.

22. The close friends interviewed were provided with a draft copy of the Overview Report prior to its finalisation and approval and their comments have been incorporated into the report.

## 7. Contributors to the review

23. Following an initial scoping exercise, three agencies contributed to the review through the submission of Individual Management Reviews (IMRs). Those agencies were:

    - Avon and Somerset Police
    - The GP practice, completed by Somerset Clinical Commissioning Group
    - Somerset NHS Foundation Trust

24. People who completed the IMRs and attended the panel were independent, in that they had no knowledge or connection with the case.

25. Diane's partner in Ireland Robert, and her friend Jenny who was present at the time of the murder contributed to the review, and took part in consultative interviews in December 2020. Another friend, Sophie was interviewed in February 2021 and another contact, Sarah, provided information. These names are all pseudonyms chosen at random, but agreed with those concerned prior to the report being finalised.

## 8. The review panel members

| **Agency** | **Representative** |
|---|---|
| Independent Chair | Steve Appleton |
| Avon and Somerset Police | Andrew Sparks |
| Clinical Commissioning Group | Charlotte Brown |
| Clinical Commissioning Group presenting the IMR for the GP practice | Joanne Nicholl |
| Safer Somerset Partnership (SCC Public Health) | Suzanne Harris |
| Somerset Integrated Domestic Abuse Service | Leanne Tasker (to Dec 2020/ Natalie Giles (From Dec 2020) |
| Somerset Partnership NHS Foundation Trust | Julia Mason |

26. The members of the panel were independent and had no prior contact with the subjects of the DHR or knowledge of the case. The GP from the GP practice attended the panels and gave valuable insights but did have prior knowledge of both parties, and therefore the independence was provided by the CCG writing the IMR.

## 9. Chair of the review panel and author of the Overview Report

27. The Independent Chair of the panel and author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. During that time, he worked with victims of domestic abuse as part of his social work practice. He has held operational and strategic development posts in local authorities and the NHS. Before working independently, he was a senior manager for a Strategic Health Authority in Thames Valley, Hampshire and the Isle of Wight with particular responsibility for mental health, learning disability, substance misuse and offender health.

28. Steve is entirely independent and has had no previous involvement with the subjects of the review. He has considerable experience in health and social care and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

29. Steve has led reviews into a number of high-profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, and investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written numerous DHRs for local authority community safety partnerships across the country. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation.

30. Steve as independent chair and author 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.

## 10. Parallel reviews

31. There were no other parallel reviews undertaken in relation to this case. An inquest was commenced in March 2020. The Inquest File was submitted to the Coroner on 29/10/20. The Coroner's Officer reported to the DHR Chair in late January 2021 that agreements have been made with relevant Interested Persons in respect of the format for the hearing but that the Coroner waits to be able to list, but no date has yet been fixed given the current COVID-19 restrictions.

32. Avon and Somerset Police had had previous contact with Jeremy; they referred themselves to the Independent Office for Police Conduct, responsible for overseeing the system for handling complaints made against police forces in England and Wales. The IOPC completed their review in June 2020 and concluded that there was "no evidence that any person serving with the police directly caused the death of Diane or Jeremy". The report recognised that the police had acted swiftly to review Jeremy's firearm and shotgun certificates following his arrest for drink driving.

## 11. Equality and diversity

33. "The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation."[1] There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[2]

34. The panel considered the nine protected characteristics in the Equality Act and sex, in relation to Diane, was found to have direct relevance to the review. This decision was taken in the context of the greater prevalence of domestic abuse and violence perpetrated towards women, thus as a woman, Diane was at greater risk. The panel ensured that the review always considered issues relating to the nine characteristics in their thinking about the engagement and involvement of organisations and professionals and

[1] Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47
[2] Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty

where identified, the impact of them on decision making and whether these presented a barrier to accessing support and assistance.

35. Diane was aged 57 at the time of her death. Her estranged husband, Jeremy who killed her, was aged 67 at the time of his death. Both were white British.

## 12. Dissemination

36. The Overview Report will be sent to all the organisations that contributed to the review. In addition, an appropriately anonymised electronic version of the Overview Report will be placed on the Safer Somerset Partnership domestic abuse website Domestic Homicide Reviews (somersetsurvivors.org.uk) A copy will be provided to the Police and Crime Commissioner.

37. Members of the family have been provided with copies of the Overview Report. A member of the family was able to meet (virtually) with the Chair to discuss the draft before the report was finalised. There were no amendments to be made to the report following this meeting.

## 13. Background information (The Facts)

38. Diane and Jeremy moved to their first home in Somerset from Sussex in 1998 and to their second and final home in the county in approximately 2015. They were active members of a dog breeding and training society and the Kennel Club. They were both keen participants in country sports and both held firearms licences and possessed a number of guns, including shotguns. They jointly ran a dog breeding and training business.

39. Diane's father had run a gun shop in East Sussex and when he died, a number of his personal firearms came into Diane's possession. Jeremy also possessed his own guns, some of which were antiques.

40. The couple separated in December 2019 when Diane went to live with a new partner in Ireland. In February 2020 Diane returned to their house in Somerset to collect some personal belongings. Whilst at the address, Jeremy shot Diane before shooting himself. Diane was found dead at the scene and Jeremy died in hospital five days later from his injuries.

41. A Post Mortem examination was conducted Diane by a Home Office Pathologist. She found the cause of death to be shotgun wounds to the chest, which would have been rapidly fatal. Post mortem toxicology tests for Diane showed no alcohol and no drugs present at the time of death.

42. A Home Office Pathologist conducted a Post Mortem examination on Jeremy. She found the cause of death to be a shotgun wound to the head.

43. Post mortem toxicology tests were not performed because there being no suitable samples that would give any indication of drugs/alcohol present in this system at the time of the incident due to the time spent in hospital undergoing treatment between the incident and his death.

44. Diane and Jeremy's deaths attracted a significant degree of media attention in the local and national press.

## 14. Chronology

46. A combined chronology has been developed and has been provided to the Home Office separately to this Overview Report. The detail of dates and types of contact are contained in the chronology document and have been drawn from the IMRs and their chronologies.

## 15. The views of Diane's partner and her friend

### The views of Diane's partner

47. As part of the DHR, the Chair was able to make contact with Diane's partner, who she had gone to live with in Ireland at the end of 2019. Following an introductory letter, emails were exchanged and a date for a discussion was fixed. The discussion took place in December 2020 and was conducted by telephone.

48. The Chair started the conversation with Diane's partner, Robert by offering his condolences and explained more about the DHR process, building on the information that he had shared in his letter seeing Robert involvement in the review.

49. Robert lives in Ireland, on a farm that has been in his family for many years. He was born in Africa but returned to Ireland in 1966. He spent some time at boarding school in the north of England and also spent some time living in Canada. He was married in 1981 but separated from his wife about three years ago.

50. Robert had known Diane and Jeremy for about 25 years. They had met through a mutual friend; this was the friend of Diane's who was present at the property when the incident occurred.

51. He talked about how Diane's father had owned a gun shop in Sussex and that she had later become a firearms dealer. She had inherited a lot of her father guns when he died. He said she had brought these with her to Ireland and that she was familiar and comfortable with guns. He said that between them Diane and Jeremy had a "quite a considerable arsenal".

52. Robert described how Diane had been a successful dog breeder and trainer, with some high profile clients.

53. The friends all shared a mutual interest in fishing and outdoor pursuits. He recalled first meeting Diane on a fishing trip in Scotland. This trip became an annual event, which he attended with Diane and Jeremy and other friends. He did recount that Jeremy did not always accompany Diane on these trips.

54. Robert recalled that he had been to stay with Diane and Jeremy at the home on a number of occasions. He described the location as being extremely rural and remote, with no other houses close by and a long roadway to the property.

55. Robert described how his relationship with Diane had been entirely platonic and that there had been no 'romantic involvement' until the summer of 2019. However, he did indicate that they were close friends and that Diane often confided in him, as well as with other friends.

56. He described how he was aware that Diane and Jeremy had experienced difficulties in their relationship for some time. He believed that some of this began about 10 or 12 years ago. He became aware of her being unhappier about two years before she left Jeremy, in around 2017. He said that Diane had told him she 'wanted to get out' and wanted a clean break with Jeremy.

57. Robert described how he felt close to Diane, but also felt guilty that people would think that he would have an ulterior motive if he sought to help her. However, he said that he had 'offered her refuge' by suggesting that she could move in with him, and that their relationship became a romantic one in October 2019. Diane moved in with him in December 2019.

58. He said that in the period before Diane moved in with him, they had become very close and that she wanted to spend the rest of her life with him. She was still in contact with Jeremy throughout the time she was in Ireland, sometimes daily, as he needed help with practical tasks. Robert indicated that Diane had run the household and done everything for Jeremy, so this contact was a way of her trying to support him despite having left. Robert said he felt sorry for Jeremy during this period.

60. Robert described that he was aware that Jeremy had been drinking heavily for many years. He said that when Diane had been unwell and treated for cancer, she had asked Jeremy to stop drinking, but his abstinence was sporadic and did not last. Robert said Diane had told him that Jeremy did not support her during her period of cancer treatment and did not attend hospital appointments with her. He said that Diane had described this as being a turning point in her relationship with Jeremy, and she felt he had effectively 'abandoned' her.

61. Robert said he hoped that when Diane moved in with him they would spend the rest of their lives together.

62. Diane told Robert that Jeremy was never violent towards her but that he was 'mentally abusive'. He described examples of this that he had both observed and been told about by Diane and other friends. They included Jeremy making dismissive and derogatory remarks about Diane, sometimes directly to her, as well as to friends, both in her presence and when she was absent. Robert described how Jeremy would use 'belittling language' about Diane and would also do this in relation to female friends. Robert also indicated that there were occasions when Jeremy would not speak to Diane for a period of many days.

63. In the period leading to Diane's death, Robert described how she had returned to Somerset on her own. The purpose of her visit was to retrieve some of her possessions and also a dog. In the light of what happened, Robert said that he now regretted not going with her, but she had told him it wasn't necessary.

64. His son, who lives with him, had a friend arriving from New Zealand and had gone to the port to meet him. This was in the late afternoon/early evening. While his son was out, Robert received a phone call from a male friend, Patrick, who was close to Diane, indeed Robert said that Patrick had been treated like "the son Diane and Jeremy never had".

65. Patrick told Robert that Diane had been shot and killed. Shortly afterwards, Robert was visited by two Garda officers who formally advised him about what had happened, though they had very little information at that point.

66. Robert described how he telephoned the friend who had been present during the incident. She provided him with some information but did not share all

the detail. He also shared that Patrick was the main beneficiary of Diane's will and that he helped to organise the funeral.

67. Robert said he was glad to be able to contribute to the DHR and hoped that it might shed some light on the circumstances of Diane's death, including how Jeremy was able to have access to a firearm. The interview concluded after about 90 minutes and the Chair again offered his condolences. The Chair has remained in contact with Robert and has liaised with him about providing a personal statement, which is at the start of this report.

**The views of Jenny, a friend of Diane and Jeremy**

68. As part of the DHR the Chair was able to speak with Jenny who was a close friend of Diane and had known her and Jeremy for a number of years. The interview was conducted via video conference in December 2020.

69. Jenny described her professional background, noting that she had worked in the NHS for a number of years as a clinician. She had first met Diane while undertaking her professional training. At the time she was living in London and had got a dog. Diane and Jeremy were then living in Sussex. They met at a gundog club where they were all training their dogs. She recalled this being in about 1998.

70. She described how she and Diane had 'hit it off' immediately and spent a lot of time together, including attending a residential training course. As their friendship developed, Jenny spent time with Diane and Jeremy at their home and went on a regular fishing trip to Scotland with them, though Jeremy did not always attend.

71. After Diane and Jeremy moved to Somerset, Jenny moved to Devon. Whichever property they lived in, she sometimes looked after their house and smallholding when they were away. She described the very remote location of the property, which was up a long driveway. There are only a couple of other houses close by.

72. Jenny described Diane as "a force of nature", someone who was always very busy, full of life and vivacious. She was generous in her friendship. She had a number of male friends, which Jenny attributed to the fact that Diane had been brought up in a masculine world. She believed she was Diane's first close female friend, but that she had made other female friends in more recent years.

73. She described Diane as someone who had a lot of energy, who could sometimes be bossy but well intentioned. Jenny said that Diane could sometime deny problems or difficulties in her life and that she could adopt a "head in the sand" approach. She could be "very stoic" and Jenny said that Diane had always had to "fend for herself".

74. Diane was passionate about her dogs and loved the outdoors. Jenny described how she would often have Diane and Jeremy to stay with her at her home, as well as the trips to Scotland and to Ireland. Robert was a mutual friend.

75. Through her friendship, Jenny had come to know Jeremy well. She described him as being a "troubled man" and that he had always been this way. When all was going well he could be great company, he was very intelligent and fun to spend time with. She stated that Jeremy was prone to low mood, and that he did not like to be "alone with his thoughts" during these periods of time. She said that Jeremy could be impulsive at times, and in her conversations with him, he had told her that he knew he found it hard to face up to difficult things.

76. She said that he was not a self-motivated man, who had to be pushed to do things. "He had no work ethic" and as a result, Diane took on a lot of responsibility for both the dog breeding and training business, but also running the home and 'looking after' Jeremy.

77. Jenny said that Diane and Jeremy were "enmeshed as a couple" but that Diane would sometimes express her feeling that things were not always great between her and Jeremy, but that she would consider herself as having failed if the marriage ended.

78. Jenny described how Diane and Jeremy would "sometimes have spats" and that Jeremy often "told Diane to fuck off" when he was asked to do things. She felt that this behaviour affected their relationship.

79. When Diane was diagnosed with cancer around a decade ago, Jenny said that Diane's feeling for Jeremy began to subside. Diane fought her cancer very hard and told Jeremy she needed him to look after her. He did so for about three months but found it hard to cope. He did not support her, she had not needed that support before, but when she did need it, Jeremy could not do it.

80. Jenny said that Jeremy had experienced feelings of guilt and shame because of his inability to cope with Diane's illness and his inability to support her. He began drinking more heavily again during this period. She said she believed that Jeremy had an addictive personality.

81. Jenny described how although Jeremy often drank heavily, he could not handle alcohol well, it made him low in mood, she said this could be characterised as making him maudlin. Jenny described that Jeremy was aware of how alcohol affected him, that he had always had depressive thoughts and she believed that some of his problems related to the death of his son from a previous relationship some years before, which she said he had never really come to terms with.

82. Jenny was aware that when Jeremy was young his father, who was an alcoholic, had left the family home and subsequently took his own life. She said that Jeremy's mother was reportedly a "strong woman" but that she indulged him. When his mother remarried, Jeremy took his step-father's surname.

83. Jenny recounted that Diane's parents had divorced when she was a child. Her father had owned at least one gun shop in Sussex and he remarried. She described how Diane had left home at a very young age, reportedly living in a bedsit from the age of 12. She had always been independent, but that as she had got older she had a need for security and that this was in part, why she had not left her relationship with Jeremy.

84. Jenny said that when Diane moved to the property in Somerset where she was killed, she had found her dream home. She enjoyed the rurality of the location. The house may have extended them financially and the couple needed all their money to afford it. This was another reason why she did not split from Jeremy before, as she could not have kept the house alone.

85. Diane and Jeremy had moved to their home around five years previously. After they moved, Jeremy began drinking heavily again. He became more distant from Diane and reportedly did not touch her physically and she missed this contact. Jenny described how Jeremy appeared to withdraw from life.

86. Jenny described how Diane and Robert had been close friends for many years. They had enjoyed time together on group holidays and Diane had also

stayed at Robert house when he was abroad. Jenny felt that during these times Diane began to realise that a life without Jeremy would be possible.

87. Jenny believes that the relationship between Diane and Robert began to change around Easter 2019. He had visited Diane in Somerset, she had confided that things with Jeremy were not good, and he offered her the chance to go to Ireland and live with him.

88. Jeremy was not aware of the developing relationship between Diane and Robert However, Diane did tell Jenny she was going to leave Jeremy but not until November 2019. This did not come as a surprise to Jenny. Diane told Jeremy in December 2019 that she was going to leave, and that she was leaving to live with Robert.

89. Jenny said that she had tried to help Jeremy with practical tasks once Diane had left and to give him advice about living on his own. She said that Jeremy did not appear to react negatively to being told Diane was leaving, he appeared to accept it. Diane left within a week of telling Jeremy of her intentions, this was at the start of December 2019 and and Jenny went to Ireland to stay at her family home which is very close to the home of Robert.

90. While they were apart, Jenny said that Diane was in regular contact with Jeremy and tried to assist him with practical matters. He did try to cope alone but found it hard. He continued to drink heavily during this period. Jenny believes that Jeremy reached a view that he was unable to make a life on his own. At one stage he reportedly told Diane that she had ruined his life. He became resentful that she had left him and that she would continue to live her life in a way that was happy and similar to the way their lives had once been, he felt that he was being replaced.

91. When Diane made arrangements to visit Somerset to collect some possessions, she stayed with Jenny. They both travelled to the house on the day of the murder and went in Diane's car. They arrived at approximately 10.00 am.

92. Jenny stated that once they had arrived, something about Jeremy did not seem right, he was angry with Jenny for being there and said that her presence had "upset his plan". She said he appeared tense, but was sober and largely polite, but seemed a little agitated.

93. Jenny said that Diane realised it would be a tense occasion and did her best to do things in a civil way. Jeremy helped her to pack the car with her things. Diane wanted to take the dog for a walk before the car journey, and Jeremy offered to go with her. Jenny did not go because she did not have walking boots and the ground was wet from the rain.

94. While Diane and Jeremy were out, Jenny said she made tea and sat in the kitchen. She did not hear anything. Then Jeremy returned, carrying a shotgun. She reports that he said "I've shot her, so you can fuck off now". Jenny was disbelieving of Jeremy and went outside, where he then pointed to Diane's body. Jenny went to Diane and could see the gunshot wound but could not tell if she was still alive or not.

95. Jenny then reported that Jeremy took her to the stable block at the property and locked her inside. From there she could still see him and said she observed him cutting the barrels off the shotgun. He then disappeared and she heard a muffled shot. She waited for what she believes was about 15 minutes, when she managed to prise a grille off the window and got out of the stables. She went to Diane, who was by now deceased. She then went into the house and called the police.

96. Jenny stated that Jeremy had told her that he had killed Diane because he did not want her to have a good life with someone else. She felt he had planned his actions. She described continuing to experience a range of emotions and that she had lost a dear friend.

97. The interview ended after approximately 90 minutes, the Chair thanked her for her insights and again offered his condolences for her loss.

**Views of Sophie, a friend of Diane and Jeremy**

98. As part of the DHR the Chair was able to speak with Sophie who was a close friend of Diane and had known her and Jeremy for around 10 years. The interview was conducted via telephone in February 2021. The discussion began with the Chair offering his condolences to Sophie.

99. Sophie first met Diane and Jeremy when she and her husband moved to Somerset in 2010, having both retired from work. The couple owned a dog and were looking for someone to assist with dog training. This was how Sophie met Diane and Jeremy, and this was within one month of moving to Somerset.

100. Sophie described Diane as extremely sociable and they hit it off from the start. Diane introduced Sophie to a lot of people, which she said was great as she and her husband did not know anyone in the area, having moved from another part of the country.

101. Sophie said that dog training was initially a hobby for her, but she enjoyed it and wanted to take it further and get more involved. She attended weekend training events with Diane and they often stayed away together. Diane then got Sophie involved in a dog society, which she herself was part of. They attended and took part in many events, including dog events and country shows, meetings and social events.

102. Sophie said that Diane would also often host dinner parties, these took place at her home and she had a wide circle of friends. Sophie also described how Diane, she and Jenny would go to Ireland and stay at Jenny's home there. This was usually for a ten-day break. Sophie also talked about Diane's interest in fishing, but said that she did not go on those trips, which were usually to Scotland.

103. Sophie talked about how Diane was a great organiser, how she was always doing things for local organisations and for other people, that she had tremendous energy and drive.

104. Sophie said she got to know Jeremy quite well and that he was friendly and that they got on well. She said that her relationship with Jeremy became more difficult over time. This was because Sophie would sometimes say things that Jeremy did not agree with or didn't like; this included her occasionally challenging him about the level of his drinking and how he treated Diane. Sophie felt that Jeremy was a troubled man.

105. Sophie described how Jeremy would be disrespectful to Diane, how he called her unacceptable names and would swear at her, particularly when he was asked to do things, like household tasks. Sophie felt that Jeremy was quite lazy and that Diane was the driving force in day to day living.

106. Sophie said that she had talked to Diane about Jeremy's behaviour and that Diane had told her that at times Diane was bothered by how he treated her. This treatment often became worse when Jeremy had been drinking. Sophie felt that he did abuse alcohol, and said that he would become argumentative when drunk.

107. Sophie said that Diane would tend to gloss things over, but she would sometimes talk about her experiences. Sophie was aware that Jeremy had pushed and shoved Diane, but was not aware that any other physical abuse had taken place.

108. Sophie stated that Diane did not see herself as a victim of abuse and that she was a very strong woman. Sophie felt that Diane should have left Jeremy a long time before she did. Diane only told Sophie that she was leaving about 10 days before she left, but Sophie said she had some sense that a relationship was developing between Diane and Robert.

109. All this coincided with a difficult time for Sophie, as her husband was unwell and his mother had died just a month or so before the day of Diane's death. Sophie recalled how she and her husband had travelled for the funeral and left their dogs with Jeremy. On their return to collect them, on the Thursday before the incident, they spoke with Jeremy. He told them that Diane was returning to collect possessions and a dog. Sophie and her husband said they would see Jeremy on the following Sunday.

110. On the day of Diane's death, Sophie sent a text message to Jeremy offering support and good luck for the day ahead.

111. At about 2pm that day, Sophie received a Facebook Messenger message from Jeremy saying that things had not gone well. Sophie tried to call him on the landline phone (mobile phone coverage was very poor due to the rural location). He did not answer so Sophie messaged back, Jeremy replied to say he did not want to talk. He then sent a further message saying that "Diane is dead and so will I be soon."

112. Sophie said she could not think straight and her first thought was to go to the house. She tried to call Jenny, as she knew that she was accompanying Diane. She could not raise her on her mobile, again due to lack of mobile phone signal coverage. Sophie then decided to call the police and she made a 999 call. This lasted around 40 minutes while they took details and tried to locate the property.

113. Sophie then received a phone call from Jenny who told her what had happened.

114. The conversation ended after about an hour and the Chair thanked Sophie for participating in the process and again offered his condolences.

**View of Sarah, a friend of Diane and Jeremy**

115. Sarah who had known both Diane and Jeremy for about 20 years offered some observations from her contact with them.

116. Sarah said that Jeremy had not been supportive when Diane had been diagnosed with cancer. She felt this was when things began to change in their relationship and she draw more support from Robert

117. She believed that Diane and Jeremy had what she described as a 'fractious' relationship, and that at social gatherings there was always an underlying tension. They had a large social circle, but some of their friends took sides when the couple separated. There was a view among some friends that even if there were problems, they should have stuck it out.

118. Sarah said that Jeremy did not know how to cope without Diane. Although he had always drunk a lot, and Sarah believed he was an alcoholic, Jeremy had been abstinent for about year but restarted prior to Diane leaving. She was aware that Diane had maintained contact with Jeremy when she was in Ireland.

119. Sarah stated that Jeremy had experienced depression over many years and that most of their friends attributed this to the loss of his son.

120. Sarah said that the care of the dogs was a concern and that their welfare deteriorated after Diane left, though there had been some questions about how well they were looked after before.

121. She described the rurality of the property, and that it was very isolated. She felt that Jeremy losing his driving licence had a detrimental impact on him. He had already felt lonely being there. She indicated that Jeremy had made plans to go away in the period after Diane left him, but his inability to drive meant he had cancelled his plans prior to Diane's return.

122. Sarah felt the drink driving offence and the loss of his driving licence was the final straw for Jeremy. She felt that if that had not happened then things might have turned out differently.

123. She said that although the police had removed the guns from the property, there were still three guns that were mounted on the ceiling. She believed that these were 'ornaments'. She stated that Diane had told her that one of these guns had not been decommissioned and it was this gun that Jeremy used to shoot Diane. These guns were hung between the beams in the house, which she said was quite dark, so it would not have been easy to see them.

## 16. Overview

124. Drawing on information from the IMRs, this section provides an overview of the contact between agencies and Diane and Jeremy. It summarises the information known to the agencies and professionals about them and any other relevant facts. It is deliberately structured by agency as the chronology already provides a lateral timeline. Where issues of relevance occurred outside the timeframe for this review, they have been included.

125. The review panel recognises that for DHRs the focus would usually be more the victim, but given the nature of this review, it has been necessary to give some focus to Jeremy as the perpetrator in order to ensure the appropriate learning for all agencies.

### Avon and Somerset Police

126. The police had no previous contact with Diane prior to her death. A search of the Police National Computer confirmed that she had no convictions, warnings or impending prosecutions.

127. Diane had a total of seven firearms records, only two of which were current at the time of her death. One was a shotgun certificate and one was a firearm certificate. One was cancelled at the start of April 2020. At the time of the IMR being produced, one certificate remained current.

128. Their only contact with Jeremy was for a drink driving offence, which resulted in the removal of his firearms licence from the former marital home. The case was discontinued after his death. The Police National Computer Search showed that there was one non-conviction for driving a motor vehicle with excess alcohol but no other convictions, warnings, cautions or penalty notices.

129. In early February 2020 the police received a 999 call from a member of the public reporting a car stuck in a ford. The police attended the scene within 15 minutes of the call. They found Jeremy slumped in the car, asleep in the driver's seat. He was arrested on suspicion of driving whilst unfit. He was taken to a police station for breath test.

130. While in the police vehicle being transported, Jeremy urinated in the vehicle and was further arrested for criminal damage to a police vehicle. It is also reported that while being conveyed to the police station, Jeremy removed one his shoelaces and tied it to the cage in the police vehicle. It is believed that he may have intended this be used as a ligature. When officers removed the shoe lace Jeremy stated, "I'm going to do it in the next 2-3 days and you can't stop me".

131. Once at the police station Jeremy underwent a breathalyser test, which showed him to have twice the legal limit of alcohol in his body. Officers undertook background checks and established that Jeremy held current shot gun and firearms certificates. A plan was put in place to ensure his guns were removed from his home before he was released from custody.

132. Officers informed the custody Sergeant of their concerns for Jeremy's mental health and that he may have ongoing safeguarding needs. Officers completed a mental health monitoring form, noting that a mental health assessment would be considered and support offered.

133. Officers also completed a BRAG assessment. BRAG refers to a colour-coded level of safeguarding risk that has been assigned to a case. This assessment resulted in an Amber coding.

134. An Amber coding indicates that there is no immediate risk requiring immediate safeguarding, but there may be risk of significant harm if the activity/concern continues, and requires referral to the police's Lighthouse Safeguarding Unit (LSU) for further consideration. It also noted that Jeremy posed a "significant risk to himself due to marriage breakdown and comments made about self-harm". This was sent to the LSU who reviewed it but no further action was taken.

135. The custody records referred to in the IMR indicate that a risk assessment was completed in respect of Jeremy, which noted he had previously been prescribed anti-depressants that he had attempted to, make a ligature while being conveyed and made statements about an intention to end his life. He was assessed as having a raised risk and a plan was put in place for him to be observed at 30 minute intervals.

136. A referral was made to the Advice, Support, Custody and Courts Service (ASCC) for further assessment. Jeremy reported to officers that he did not intend to end his life or harm himself and did not know why he had said what he did, other than that he was intoxicated at the time. ASCC provided Jeremy with contact numbers for local support organisations.

137. Jeremy was released from custody the morning after his detention. He was accompanied by police officers so that that could take possession of his firearms. The Firearms Licensing Bureau Manager issued a directive to seize all firearms, and if necessary to force open cabinets containing firearms.

138. The IMR makes clear that Jeremy was co-operative with the police officers throughout the process of them removing his firearms. He told them there were no other guns at the address. Officers did inspect one other gun; this was not seized as it was believed to be an air weapon. Officers saw no other guns or ammunition at the property and there was no suspicion that there were any illegally held firearms at the address.

139. The police made attempts to contact Diane about guns at the property that belonged to her. This was because Jeremy's licence gave him permission to use them. These attempts were initially unsuccessful, but the Firearms Licensing Bureau Manager confirmed to the police IMR author that they did manage to speak to Diane, who confirmed she had two guns in her possession in Ireland.

140. The IMR makes reference to the use of Body Worn Video (BWV), which was taken when officers attended to Jeremy at the scene of his drink driving offence and conveyance to the police station. The BWV was uploaded in accordance with police guidance. No BWV was taken of the firearms seizure.

141. The incident was filed, pending court appearance, but additional statements from officers were added to the Niche recording system after Diane's death. These covered the uploading of the BWV, a detailed statement from the officer who attended the drink driving incident, in which the officer outlined their view that Jeremy had suicidal ideations due to his actions and circumstances at the time.

142. There was also a statement from an officer in the Detainee Investigation Team who served Jeremy with the revocation of firearms licence and shot gun certificate. It makes clear that the appropriate paperwork was completed to submit to the firearms licencing unit.

143. The statement also makes clear that while the officer did have BWV on during the process, the officer did not mark it as evidential at the time, so had asked the digital policing unit to retrieve it.

144. The authorised firearms officer made a statement regarding their visit to the police station to make the seized weapons safe. It confirms that the weapons were made safe, tagged and checked against the serial numbers on the shotgun certificate.

145. The second and final police contact in this case was in relation to the incident that resulted in Diane's death and Jeremy's subsequent death.

146. The police received a 999 call from a friend of Diane's. The friend called regarding a message she had seen on Facebook posted by Jeremy. The message read "D is dead, I will be in a moment, so sorry". A further call was made to the police 18 minutes after the first one. This second call was made by Diane's friend who was present at the property and was, as described earlier, in the stable block. She told the police that Jeremy had shot Diane.

147. Officers were dispatched within 10 minutes, and they were followed by Authorised Firearms Officers (AFOs) and a police helicopter. The ambulance service was notified and requested to attend.

148. THRIVE, a nationally implemented risk assessment tool was used, and as a result, local police units were stood down until the AFO's arrived at the scene. A force negotiator was also deployed and contact was made with Devon and Cornwall Police, given the location was close the border of the two force areas.

149. Following police attendance a Sudden Death Report was completed and statements were taken from the two 999 callers. The first of those callers stated to the police that "when drunk Jeremy would be verbally abusive towards her (Diane) and although she said he would not be violent had said that he had pushed and shoved her". The witness also stated that she had never seen Diane with any injuries and that Diane had told her that Jeremy had never hit her.

150. Following the incident a Community Impact Assessment was considered and the Professional Standards Department was notified due to the previous police contact with Jeremy in relation to the drink driving offence earlier in the month.

151. A full police investigation was launched into the death of Diane, which later also encompassed Jeremy's death. Once Jeremy died, the investigation did not proceed, as there was no scope for prosecution.

**Somerset NHS Foundation Trust**

152. Somerset NHS Foundation Trust provides community, mental health and acute hospital services. They provided an IMR because both Diane and Jeremy had contact with the Trust's services prior to their deaths. Those contacts were limited, but the panel requested an IMR so that information of those contacts could be gathered.

153. The IMR states that in the period covered by the DHR the Trust had two contacts with Diane and three contacts with Jeremy.

154. Diane's contacts related to two outpatient appointments at the hospital. These took place in January 2017 and February 2020, just three days before her death.

155. These were recorded as routine appointments. They related to investigations into and treatment for Graves' Disease at the Endocrinology Department.

156. Graves' disease is an autoimmune condition where the immune system mistakenly attacks the thyroid, which causes it to become overactive. The cause of Graves' disease is unknown, but it mostly affects young or middle-aged women.[3]

[3] https://www.nhs.uk/conditions/overactive-thyroid-hyperthyroidism/causes/ Accessed January 2021

157. In neither of these appointments was there any discussion of domestic abuse and no evidence that any discussions took place that revealed information that would have prompted further routine enquiry.

158. Jeremy had only three contacts with the hospital in the period covered by the DHR prior to contact with the ASCC following his arrest for the drink driving offence. The two contacts related to issues with knee pain and also a urology appointment.

159. The first two recorded appointments were in mid-January 2018 and then February 2018. They were related to Jeremy's concerns about ongoing knee pain. He was reviewed and then referred to surgeons for an arthroscopy. There is no information available about whether that procedure took place and if it did, what the outcome was.

160. In late January 2020 Jeremy attended the hospital following a referral by his GP, having complained of experiencing increased frequency of urinating. The notes reviewed for the IMR indicate only that flow tests were requested and the outcome was that Jeremy should liaise with his GP about the outcome. There is no information about any next steps that were taken. The notes do indicate that during the appointment Jeremy was noted to have recently started anti-depressant medication following the separation from Diane.

161. In none of these appointments was there any discussion of domestic abuse and no evidence that any discussions took place that revealed information that would have prompted further routine enquiry.

162. The ASCC service assessed Jeremy following his detention for the drink driving offence. This assessment took place in the custody suite of the police station. During the assessment Jeremy declined to give his consent for information gathered to be shared with other agencies. The IMR states that Jeremy presented as sober and bright of mood during the assessment. He reported regretting the actions that had led to his arrest and indicated that he was struggling as a result of Diane leaving him and now having a new partner in Ireland.

163. Jeremy reported that he had no intention to harm himself or to end his life, not had he had any previous thoughts of self-harm or suicide. The assessment did not elicit any evidence of domestic abuse or threats to harm Diane.

164. Jeremy was discharged from the ASCC service and provided with contact information for local support agencies prior to his release from custody.

165. Other than this contact with the ASCC, Jeremy had no contact with secondary mental health care services.

**GP Practice**

166. Both Diane and Jeremy were registered with a local General Practice. The IMR completed by the Clinical Commissioning Group notes that in the period covered by the DHR Diane had 40 contacts with the practice and Jeremy had 23 contacts with the practice.

167. Although the records reviewed covered the period back to 2015, the IMR states that there was a list of active medical issues dating back to 2001. The contacts that Diane had with primary care were reviewed by the IMR author and were related to largely minor physical health issues.

168. It is known from the discussions between the Chair of the DHR and Diane's friend, that Diane had previously been diagnosed with cancer a decade before her death. That diagnosis and treatment fell outside the scope of the timeline for the DHR but is mentioned here, given that in the course of the discussions with her friend, it was suggested that this was a significant turning point in her relationship with Jeremy.

169. Diane was in contact with primary care in relation to investigations and treatments for hyper-thyroidism, also known as Graves' Disease. At various consultations Diane reported some difficulties with sleeping but these are described as related to her physical health rather than mental health issues.

170. In October 2017 Diane consulted her GP. She reported having difficulty sleeping since a previous serious health problem. She was prescribed a short course of sleeping tablets and advised to return if things did not improve.

171. There is mention of a road traffic accident in 2018. Diane had been the passenger in the back of a pick-up truck that had to brake suddenly. She was not wearing a seatbelt and was flung forward against a metal bar, and two other passengers fell on her. She had injured her ribs and one of her fingers. She consulted the GP and was referred to a specialist for the finger injury.

172. In March 2018 the police wrote to Diane's GP for information relating to the issuance/renewal of her firearms certificate. The IMR indicates that there was no mention in the course of that correspondence about any difficulties in her relationship with Jeremy.

173. Diane's final recorded contact with the GP practice was in October 2019, this for the removal of a pilar cyst from her scalp. Cysts that form around hair follicles are known as pilar cysts. They're often found on the scalp. Pilar cysts typically affect middle-aged adults, mostly women.[4]

174. The IMR notes that none of Diane's contacts with the GP practice indicate that there were no issues that would have raised concerns from the GP in relation to domestic abuse, or for any form of routine enquiry.

175. Jeremy's contact with the GP practice locally within the period of time for this review is first recorded in early 2015. However it is helpful for the review to note that between November 2012 and January 2019 there was only one contact with the GP practice in relation to his mental wellbeing and one contact in relation to difficulty sleeping. In the contact relating to his mental health and wellbeing, in October 2014 he described feeling stressed, tired and 'a little depressed'.

176. In February 2015, he consulted with his GP, as he was experiencing insomnia that had been ongoing for a number of years. He reported that the cause of the sleep disturbance was worries about his wife's cancer. He also talked about the death of his son from a previous marriage. He denied drinking alcohol. He was prescribed a one-week course of sleeping tablets.

177. In 2017 Jeremy made an application for a firearm/shotgun certificate. The records reviewed by the IMR author indicate that the application was sent to the GP practice. It is noted that although there had been consultations with the GP in 2011 and 2012 about his mental health and wellbeing and drinking, he subsequently reported in November 2012 that he had 'stopped drinking' and was 'feeling better'.



[4] https://www.nhs.uk/conditions/skin-cyst/

178. It is also noted that in the previous five years that there had only been one contact with the GP practice in relation to his mental health and wellbeing in which he reported that him 'thinking he was a little depressed' in 2014. The form that the GP practice received from the police only required a response if there were any concerns that that the police needed to be made aware of. GP did not report any concerns to the police in relation to the application.

179. There is nothing in the records to indicate that the GP responded to the request. The standard process is that if a GP has no concerns then they do not need to reply to the request. It is assumed that this is what happened given that Jeremy did hold a valid certificate, which was then revoked following his arrest for drink driving.

180. In January 2019 Jeremy had contact with his GP. The IMR states that he was experiencing low mood and had relationship difficulties. He was not sleeping well, felt emotional but denied thoughts of self-harm or suicide. He reported being concerned about Diane, saying he thought she was unwell and that she was not speaking to him about anything.

181. Jeremy reported that he had previously found anti-depressants helpful; this appears to have been in 2011 or 2012. He did not wish to have talking therapy intervention. The GP prescribed an antidepressant, Sertraline.

182. This was followed up at subsequent appointments and in July 2012 he reported that he was feeling much better since seeing a professional with regard 'has stopped drinking two months ago gets the odd craving but not strong' 'much better relationship with wife now and enjoying job' The GP noted that he ' looks well and much more relaxed'.

183. In January 2019 Jeremy visited the GP complaining of back pain but also mentioned low mood. He reported having relationship problems and that his wife had not been speaking to him. He was concerned about her health and stated that he 'felt emotions' but did not elaborate or clarify what he meant by this.

184. The next recorded contact in the IMR is in June 2019. Jeremy again related issues with sleep and mood. He said Diane was due to go away for a month. He denied thoughts of self-harm or suicide. Treatment with Sertraline, an antidepressant was restarted.

185. In September 2019 Jeremy had a further consultation with the GP. He noted that there had been some issues in his relationship with Diane, but that all was now well and he was feeling better. He stated that Diane was a different person after her time away and that their relationship was much better than it had been. Jeremy was keen to reduce and then stop the Sertraline medication.

186. In November 2019 Jeremy had a phone consultation with the GP. He was experiencing lower urinary tract symptoms, and was getting up in the night four times to go to the toilet. He told the GP that Diane was leaving and they were separating, but that it was an amicable split.

187. Jeremy was referred to urology for investigation. The GP received a letter from the specialist at the end of January 2020, which included reference to the relationship issues and the end of the marriage. Jeremy denied using alcohol during that consultation with the specialist and that he was continuing to take Sertraline.

188. Jeremy's last contact with the GP practice was in November 2019.

## 17. Analysis of the Individual Management Reviews

189. This section of the report provides an analysis of the information received by the DHR panel. This includes the information contained in the IMRs, and the discussions that took place during DHR panel meetings as well as that received through the conversations with Diane's partner and her friends.

190. Any issues or concerns identified are a reflection of the evidence made available. In doing so the panel have been mindful of the guidance relating to the application of hindsight in DHRs and have attempted to reduce it where possible.

### The involvement of Avon and Somerset Police

191. The police had no prior contact with Diane.

192. The first contact between Jeremy and the police took place when he was detained for a drink driving offence. Officers attended the scene in a timely way having been contacted by a member of the public.

193. Having assessed the situation, officers responded appropriately and comprehensively. Their primary response was rightly in relation to the offence of drink driving and they did so in line with the relevant legislation.

194. The police had due regard to the potential risks that Jeremy presented to himself and others in the context of his offence. They responded to those risks appropriately. They used relevant and recognised risk assessments frameworks and tools. These informed their response and led to the consideration of potential safeguarding concerns and matters relating to Jeremy's mental health presentation.

195. There were some gaps in the recording of the police decisions, which should have been noted on the NICHE system. Although this did not happen, there was no direct impact on the interventions conducted.

196. In relation to the possible involvement of adult social care, the IMR notes that the police conducted a review and this concluded that the threshold for any referral to adult social care would not have been met. This was primarily because Jeremy had capacity and there was nothing that suggested his was at risk of abuse or neglect.

197. The police appropriately made a referral to mental health services while Jeremy was in custody.

198. The police quickly established that Jeremy was a firearms holder and noted to risks associated with this. They took swift and clear decisions to mitigate the risk. There is clear evidence from the IMR that there was appropriate consultation with a senior police officer and the firearms licencing team to put in place a plan to deal with this prior to his release, specifically, the seizing of his firearms.

199. The seizure of Jeremy's guns was undertaken in accordance with national legislation and policy guidance. There is no requirement for the seizure and making safe process to be recorded on the NICHE system. This is also the case for the revocation of a firearms licence. As such no immediate record was made of issuing the notice of revocation to Jeremy, or of the seizure and make safe process.

200. This was recorded retrospectively at the request of the Senior Investigating Officer after Diane's death. It confirmed that Jeremy had not made threats to harm Diane or made any comments of concern to officers during the process of seizing his guns.

201. No BWV footage exists for the seizure process, this is because it was not an evidential process. Even if it had been recorded, it would have been deleted after 31 days unless it had been marked as evidential. Officers did not act incorrectly in this regard. However, this points to a possible gap in evidence that could have been helpful following Diane's death.

202. There is no evidence in the IMR that officers believed Jeremy to be in possession of illegally held firearms. They therefore had no lawful basis to search his property for other guns. The IMR author concludes that there was no missed opportunity to prevent to circumstances of Diane's death.

203. The information provided to the DHR by Diane's friends suggests that the weapons that remained were ornamental and may not have been clearly visible. Given the lack of BWV it is not possible to reach any reliable view about how easy or not it would have been for officers to spot those weapons or to question Jeremy about them. However, they were working on the basis that he did not hold any firearms other than those that were licensed.

204. The investigation of Diane's death and Jeremy's subsequent death is not in the scope of the DHR. The IMR does identify that the gun Jeremy used to injure himself, which is also suspected of being the same weapon used to shoot Diane, was not licensed and therefore held illegally. It is not clear to the police who owned the gun. There was also one other unlicensed shot gun found at the property and several air weapons which were not subject to firearms licencing conditions and were therefore not seized. All guns and ammunition were seized after Diane's death.

205. There were no examples of concerns identified by the police in their dealings with Jeremy prior to Diane's death that domestic abuse was present in his relationship with Diane before she left him, nor that he presented any risk to her.

206. The LSU did not let the GP know of Jeremy's arrest or that he had expressed suicidal ideation while in custody. This would have been a helpful communication and provided the GP with an up to date picture of his circumstances.

207. The police IMR recommendation is set out later in this report.

**The involvement of Somerset NHS Foundation Trust**

208. The contacts between the Trust, Diane and Jeremy were for mainly for routine physical health issues. The only exception to this was the contact between the Advice and Support in Custody Support Service (ASCC) and Jeremy while he was in custody following his arrest for a drink driving offence.

209. The contacts between the Trust's staff in relation to both Diane and Jeremy's physical health were appropriate and in line with recognised national clinical governance frameworks and standards.

210. At no point in any of her contacts with the Trust did Diane refer to or disclosure any issues relating to domestic abuse. This meant there was no need for the use of routine enquiry.

211. When Jeremy was seen by the ASCC he was appropriately assessed. His mental health was properly considered and he did not meet the threshold for onward referral to specialist services. Jeremy did not consent to his information being shared with other agencies that he could have sought support from. Jeremy was deemed to have capacity to make this decision.

212. The assessment was properly and accurately recorded by the ASCC and they correctly provided Jeremy with information about local support services.

213. The Trust IMR does not make any recommendations.

**The involvement of the GP Practice**

214. The contact between the GP practice and Diane and Jeremy was conducted within the expected clinical governance frameworks and standards that would usually be expected.

215. Much of Diane's contact with primary care related to physical health issues. These were largely routine at first, later they related to matters concerning her cancer diagnosis. In the period covered by the DHR these contacts were minimal and there were no issues relating to domestic abuse. The nature of her relationship with Jeremy was not covered in conversations between Diane and professionals working in the GP practice, nor did Diane present with any issues that might have prompted enquiries about her relationship.

216. Diane did raise concerns about sleep disruption but the GP did not enquire further about any specific factors that might have been contributing to her sleep problems.

217. The IMR concludes that this was a missed opportunity to enquire more deeply about potential causes of her sleeping difficulties and any mental health issues that she might have been experiencing as this may have opened up a conversation about relationship difficulties. Although on both occasions, Diane described a physical cause of the sleeping difficulty (symptoms of hyperthyroidism and cancer), the IMR notes that depression sometimes presents as sleep disruption, notably early morning waking.[5] Given Diane's cancer diagnosis and treatment she may have experienced concerns about her ongoing health and this might have affected her mood, sleep and relationship.

218. When Diane presented to the GP practice following a Road Traffic Accident (RTA), she sustained physical injuries including to her ribs and fingers. There was no evidence that the injuries had been caused by anything other than the RTA, but there is no evidence that any other possibility was considered or explored. However unlikely, this exploration might have provided an opportunity to reveal any underlying concerns or issues relating to her relationship or home circumstances.

219. Jeremy's contact with primary care often related to his concerns about his mood and his wider mental health and wellbeing. On a number of occasions he was prescribed sleeping pills to assist him with disturbed sleep, which he believed was causing his low mood.

220. He had a history of low mood and intermittent depression and use of alcohol that went back over a number of years, certainly to 2006. Despite this history, Jeremy never received a formal diagnosis of depression and therefore this was not present in his medical records. However, the notes contained numerous references to his history of depressive symptoms, insomnia and alcohol use. . Prior to 2019, the last significant episode took place in 2011 and 2012, and follow up indicated that these had considerably improved by July 2012. There were two consultations, one in 2014 and 2015, and nothing further until January 2019.



[5] Sleep issues associated with depression include insomnia, hypersomnia, and obstructive sleep apnea. Insomnia is the most common and is estimated to occur in about 75% of adult patients with depression quoted in Nutt, D. et al, Sleep Disorders as Core Symptoms of Depression, National Library of Medicine 2008

221. He did talk about his relationship problems but there is no evidence that primary care professionals explored these disclosures in any detail. He also talked about the death of his son and how this had an impact on his mood. Again there is little to indicate that this was explored with him in any detail, nor is there any evidence that he was provided with any information about support that might have been available to him. He also referenced stresses at home that related to Diane's illness, but this was not explored in any detail.

222. Jeremy was commenced on antidepressants by the GP on a number of occasions but he did choose at times not to continue with these. It therefore appears that he did not continue long enough with the medication for it to have made a significant difference to his depression. This would have been his choice.

223. In 2017 the police contacted the GP as part of the process of Jeremy's application for a firearms licence. The GP (a registrar) did not report any concerns in relation to Jeremy's fitness to hold such a licence. It is noted that the form that the GP received from the police only required a response if there were concerns. Even though Jeremy's mental health was probably not seen as a current issue, it have been useful to have declared it.

224. Although there had been issues with drinking and mental health and wellbeing- these dated back to five years previously with only one contact in 2014 when he reported he '*thinks he may be a little depressed*'. The standard document used by the police to collect this information does not give guidance in relation to historical issues, not the severity of issues that they would want to see reported.

225. The IMR indicates that Jeremy may not always have been truthful with the GP practice team regarding the level of his drinking. He regarded himself as a binge drinker and this meant that he was significantly intoxicated for brief periods, for example when detained for the drink driving offence.

226. When Jeremy's firearms licence was revoked following the drink driving offence there is no evidence that this was notified to the GP practice team. If they had been notified it would have provided an opportunity for the GP to have made contact with Jeremy to check on his welfare following the revocation and the potential of him losing his driving licence.

227. The primary care IMR recommendations are set out later in this report.

## 19. Conclusions

228. Having reviewed and analysed the information contained within the Individual Management Reviews and having considered the chronology of events and the information provided the panel has drawn the following conclusions relating to organisational involvement as well as more general conclusions about this case.

229. The contact between statutory agencies and Diane and Jeremy was very limited. They had not been engaged with any services or agencies in the period covered by the DHR in relation to domestic abuse matters. Their contact with agencies was largely routine, and in the case of primary and secondary care NHS services, the result of general health concerns.

230. The police responded appropriately in relation to Jeremy's drink driving offence. They paid necessary regard to his mental health and wellbeing and engaged the ASCC service to assess him.

231. The ASCC conducted a thorough assessment, paid regard to issues of consent and reached a clear decision about their actions and provided Jeremy with information about support services.

232. The agencies that had contact with Diane and Jeremy treated them with respect and their inputs were provided in line with relevant policy and guidance.

233. The conversations with Diane's partner, and friends revealed a pattern of behaviour by Jeremy towards her that could constitute coercion and control. This was characterised by him regularly belittling her verbally and using abusive language towards and about her.

234. This may point to a wider lack of awareness of domestic abuse among members of the public and unwillingness to report it. This could be for a variety of reasons, not least a wish not to be seen to be interfering in the private lives of others. It may also be that the nature of coercive control, although now gaining greater prominence, is not widely known about or understood by members of the wider public and thus by families of those who experience it.

235. There is evidence that Jeremy may have physically assaulted Diane by pushing her on more than one occasion. She did not report this to the police but did mention it to friends.

236. Diane clearly took the lead in running the couple's business. It was noted by the panel that she held the responsibility for the financial health of the business and for the couple personally. Some may interpret Jeremy's behaviour as economic abuse by making Diane responsible for the business and exploiting her economic resources by not contributing. It was the conclusion of the panel that there was insufficient evidence to reach such a definitive judgment, but it was recognised that there was a clear financial imbalance in the relationship that affected Diane directly.

237. There is no evidence that any agency in contact with Diane or Jeremy every enquired about issues relating to domestic abuse. This may be explained by there being no apparent evidence or reason to make any such enquiry. However, in the context of their respective sleep issues, this was not explored to understand if there were any emotional or other reasons that were impacting on Diane's ability to sleep. In the context of Jeremy, where he talked about issues in his relationship as well as other factors, these were not then used as means to undertake any further more detailed exploration or inquiry of whether there was any domestic abuse taking place in the relationship.

238. The issue of Jeremy's application for a firearms licence is pertinent to this DHR. The police made enquiries of the GP as part of the application process. A GP registrar rather than a more senior GP reviewed this. It is understood that this GP did not have direct contact with or wider knowledge of Jeremy but would have been under the supervision of a more senior GP.

239. The way in which decisions are made by GPs in responding to such enquiries is not subject to any recognised national framework that would infer any degree of consistency. In this case, the fact that Jeremy had displayed depressive symptoms and had a history of heavy drinking, both five years previously may have been relevant. However, the lack of clarity in the guidance about what level of mental health concerns might contribute to a decision not to recommend a person for such a licence, or how far back to go in a person's history was also a factor that led to challenges in understanding what information is and is not relevant should be included. More detailed guidance may have prompted better and more effective information sharing.

240. It is important to also recognise that GP's have to strike a fine balance in this decision making. They undertake the assessment and decision making in an autonomous way, without overarching national guidance, in the knowledge that their decision may have a significant impact on the person, possibly their livelihood and their wellbeing. In the same way decisions about revocation of a driving licence can have a similar impact, however, DVLA guidance provides a helpful framework for all professionals to follow.

241. In relation to decision by the police to revoke his firearms licence and seize his guns was appropriate in line with relevant legislation.

242. The Firearms Act 1968 specifically states that a firearm certificate may be revoked if the holder is "of intemperate habits or unsound mind or is otherwise unfitted to be entrusted with a firearm". Furthermore, The College of Policing Authorised Professional Practice (APP) guidance on Firearms Licensing mandates that licenses are subject to continuous monitoring and risk assessment and will be revoked if there is a concern for safety. This is based on a professional judgement and will be authorised by the Licensing Bureau Manager (or deputy) who has delegated responsibility from the Chief Constable.

243. On the basis of the information provide the DHR panel has concluded that the process around the seizure of the guns was in line with this guidance. The police took quick and decisive action to seize Jeremy's guns to safeguard him and others.

244. Both Diane and Jeremy had a long history of gun ownership, and participation in country sports. Their use of guns was not regarded as a risk within their relationship with each other or with any other party.

245. Jeremy's firearm certificate showed his latest shotgun and firearms certificates had been revoked 11 days before he killed Diane. He had six previous shotgun/firearm certificates, which had been cancelled due to transferring out to a different police force area in around the year 2000.

246. The DHR panel has concluded that the matter of how the weapon Jeremy used to murder Diane was left in the house is not one that is directly in the scope of the review. The panel has however discussed the issue and noted that the police had no reason to suspect that there were any unlicensed, activated weapons at the property and as such, had no evidence or basis upon which to conduct any further search of the property. They acted swiftly to revoke his forearms licence and the remove those licenced weapons, the panel also notes that Jeremy was co-operative during the seizure process.

247. Notwithstanding the conclusion that the process around gun seizure was conducted in accordance with national legislation and guidance the DHR panel has concluded that there are areas for improvement. Specifically this relates to the lack of immediate recording of the process on the NICHE system. This was only done retrospectively and although this was not an oversight, it has highlighted the fact that there is no requirement for such recording and the DHR panel concludes that this is an issue of practice that needs to be addressed. This is not just a matter for Somerset but nationally too.

248. This also applies to the use of BWV, which unless deemed evidential, is not routinely used or kept in the process of firearm seizure. The IMR concludes that this is a matter of procedural guidance that should be updated and the DHR panel concurs with this view.

249. Although the contact with agencies was limited, there was a lack of professional curiosity. This meant that where there were apparent clues about difficulties in the relationship described by Jeremy were never explored or probed with any depth of detail.

250. The information gleaned from Diane's partner and others has shown that Jeremy's alcohol use; history of depressive symptoms and low mood and behaviour towards Diane was of long standing. Although they expressed concerns between them, there was no indication that he would harm her or be a risk to her life.

251. The nature of the relationship between Jeremy's mental health and alcohol misuse was not adequately considered or addressed. The misuse of alcohol places individuals at greater levels of risk in relation to physical and mental health, their financial circumstances and their relationships, as such the

Institute of Alcohol Studies suggests that it can increase an individual's overall risk and also in some cases their own vulnerability.

252. Research to indicate that alcoholism and drug abuse causes domestic violence is limited but that which exists indicates that among men who drink heavily, there is a higher rate of assaults resulting in injury.[6] Evidence suggests that alcohol use increases the chance and gravity of domestic violence, showing a direct correlation between the two. Because alcohol use affects cognitive and physical function, it reduces a person's self-control and lessens their ability to negotiate a non-violent resolution to conflicts.[7]

253. The DHR panel has concluded that the rurality of the property contributed to Jeremy's low mood after Diane left him and he had been arrested for drink driving. It contributed to his sense of isolation and impacted his ability to travel. The DHR panel notes this, not as an excuse for his actions, but to highlight the effect this isolation had on him and the part it played in his mental wellbeing.

254. The loss of Jeremy's driving licence also led to further isolation and the loss of his gun licence would have had an impact on his social and work life. The mental health team, who failed to inform the GP which meant that the GP could not support him, did not consider this.

255. The impact of Diane's death has had a lasting impact on her partner in Ireland and her friends, one of who was present when she was killed. This represents a significant trauma for them, her wider family and friends, and the panel again extends its condolences to them.



[6] Very Well Mind – international online research library accessed February 2021
[7] American Addiction Centers alcohol.org accessed February 2021

## 20. Lessons learnt

256. The majority of the lessons learnt from this review are contained within the conclusions. However there are some specific learning points that the DHR panel have identified. These are as follows:

257. There is an apparent lack of national practice guidance relating to how GPs review and respond to applications for firearms licences. There is a variable practice in Somerset and it is likely that this extends nationally. The key lesson here is that without clear guidance, this variance of practice is likely to be maintained. This means that decision-making is left to individual practitioners and will be based largely on their knowledge of the specific person to whom the application applies. In some circumstances the GP may not have an in depth knowledge of the person and therefore increases the need for clear and detailed guidance.

258. Jeremy displayed behaviour towards Diane that could be characterised as coercive and controlling, this included the undermining and belittling language he often used towards her and about her to others. The DHR panel knows from the discussions with Jenny that she and other friends of the couple were aware of the difficulties between them and recognised the increasingly abusive nature of Jeremy's behaviour. Those friends often had frank exchanges with both Diane and Jeremy, going back 10 or 11 years and encouraged them to seek counselling support. Even when their relationship was tense neither of them could see themselves as being apart from one another. Jenny stated that Diane did not see herself as a victim and would often dismiss the concerns of Jenny and her other friends. She certainly had the control over the household, social events; business deals and the finances were firmly in her hands.

259. Unfortunately, as time went on it is possible that Jeremy found that the only way to feel in control was through the constant criticism and undermining, which was always worse when he was inebriated. Jenny said that friends did rally round to try and support Jeremy when Diane left, that he did try to live on his own, but he had always lived with a strong woman to support him. It was when Diane decided it was time to look after herself that led Jeremy to become confused and then resentful.

260. Jenny advised that she knew from a close male friend that during that last week or so, Jeremy veered from being maudlin and tearful to angry and vengeful. This person feels deep regret and guilt that he did not take Jeremy's statements when drunk more seriously. She stated that none of the couple's friends thought that he would become so disturbed as to kill Diane, only possibly himself.

261. This case demonstrates that coercive control may not always be recognised as such by the victim, or indeed their family, friends or professionals in contact with that victim. The lesson to be learnt is that work remains to be done to raise awareness of coercive control, encouragement to victims to recognise and report it, and for agencies to respond to it appropriately.

262. The DHR has revealed the limited nature of contact with agencies, and once again demonstrated that very often, domestic abuse can be largely hidden from view. It has also shows how it often requires a greater degree of professional curiosity to reveal it to those agencies that come into contact with victims but that in many circumstances this is difficult to achieve. This can be exacerbated in rural communities. A 2019 report from the National Rural Crime Network found that the more rural the setting, the higher the risk of harm, that abuse lasts on average 25% longer in the most rural areas and support services are more scarce, less available and less visible.[8] It also found that rurality and isolation are deliberately used as weapons by abusers. These are important lessons in addressing domestic abuse in rural areas.

263. A further lesson learned is the vital role that friends and associates can play in providing information and insights about the relationships being reviewed. This is especially so in circumstances when agency involvement in limited, as it was in this case.



[8] Captive & controlled, domestic abuse in rural areas, NRCN 2019

## 21. Recommendations

264. This section of the Overview Report sets out the recommendations of the DHR panel and also the recommendations from the IMRs. The DHR panel recommendations are intended to address system wide issues and to support and build upon those recommendations already made and being acted upon in the IMRs.

265. In making these recommendations the panel has been mindful that they focus on rectifying the omissions and deficits in process, policy, systems and practice that have been identified in the DHR. The panel is also aware that the recommendations may be similar to those seen in many other reviews in other parts of the country. This should not diminish their importance or the need to act on their implementation.

**DHR panel recommendations**

1. Recommendation One: Avon and Somerset Police implement their own recommendation relating to the standard operating procedure for the firearms seizure. In so doing they should liaise with the appropriate policing and justice bodies nationally to ensure that the lessons learned from this review contribute to national practice.

2. Recommendation Two: Avon and Somerset Police should put in place a process to ensure that the NICHE system is used to record and flag individuals who have a firearms licence. The DHR panel notes that this is work in progress but recommend it is completed swiftly. Again the police should liaise with the appropriate policing and justice bodies national to ensure that the lessons learned from this review contribute to national practice.

3. Recommendation Three: The Safer Somerset Partnership, in conjunction with the Avon and Somerset Police and the Clinical Commissioning Group should liaise with NHS England/Improvement, the Department for Health and Social Care and the Royal College of GPs to consider what national guidance might be put in place to ensure a more consistent approach to GPs responses to police enquiries about an individual's fitness to hold a firearms licence.

This should align with the Governments revisions to UK gun laws announced in October 2021. The government has stated that "No one will be given a firearms licence unless the police have reviewed information from a registered doctor setting out whether or not the applicant has any relevant medical history – including mental health, neurological conditions or substance abuse." [9]

4. Recommendation Four: Somerset NHS Foundation Trust should clarify with organisational partners when their ASCC would usually notify a GP when they have conducted an assessment of an individual. This might only be when a person is at risk of harm to themselves or others, but at present there is no clarity about this. This is an area of practice that needs to be improved.

5. Recommendation Five: The Safer Somerset Partnership should undertake work to establish what particular domestic abuse issues might be affected by the rurality of part of their area. They should then use this information to inform their public awareness campaigns and their local training offer.

**IMR recommendations**

*Avon and Somerset Police*

- Avon and Somerset Police should review the standard operating procedure/procedural guidance for firearms seizure and make safe processes to ensure that each part of the process is clearly and fully documented on Niche and recorded with BWV.

*Primary care*

- GP to consider more formal follow up of patients who may be presenting with depression and consider asking more in depth questions about domestic abuse in light of "stress" in the relationship

- It may be helpful to provide further guidance to GPs about what information to disclose to the police regarding shotgun licencing. Consideration should be given as to whether it is appropriate to delegate this work to GP registrars depending on their level of training in this area.

[9] https://www.gov.uk/government/news/uks-strict-gun-laws-strengthened-with-new-medical-arrangements

- Given that his (Jeremy's) mood was sufficiently low to warrant medication it would have been appropriate to inform the police in respect of his shotgun licence as per their guidance. The mention of "relationship difficulties" could have prompted a discussion about domestic abuse.

- Sleep issues should be explored in greater detail to check for any underlying causes including mental health issues and domestic abuse.