



SOUTH WORCESTERSHIRE COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review DHR Case No 6

Executive summary

**Under Section 9 of the Domestic Violence Crime and Victims Act
(2004) in respect of the of the death of a woman aged 73 years**

on 20th January 2014

**Report produced by Malcolm Ross M.Sc.
Independent Chair and Author**

13th July 2015

LIST OF ABBREVIATIONS

AAFDA	Action After Fatal Domestic Abuse
BPSD	Behaviour Psychological Symptoms of dementia
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CT Scan	Computerised Tomography Scan
DASH	Domestic Abuse, Stalking and Harassment Risk Assessment Tool
DHR	Domestic Homicide Review
DVPN	Domestic Violence Prevention Notice
EIDS	Early Identified Dementia Services
GP (VTS)	General Practitioner (Vocational Training Scheme)
HAU	Harm Assessment Unit – West Mercia Police
HM Coroner	Her Majesty's Coroner
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
MAPPA	Multi-Agency Public Protection Arrangement
MARAC	Multi-Agency Risk Assessment Conference
MDT	Multi-Disciplinary Team
NHS	National Health Service
OAMHS	Older Adult Mental Health Services
SIO	Senior Investigating Officer - Police
SWCSP	South Worcestershire Community Safety Partnership
WFADA	Worcestershire Forum Against Domestic Abuse

SOUTH WORCESTERSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW into the circumstances of the death of a woman aged 73 years on 20th January 2014

Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 73 year old woman on 20th January 2014. The woman's husband, the Perpetrator, has been arrested and charged with her murder. He appeared before the Crown Court on 26th January 2015 where he was deemed unfit to plead. On 9th February 2014 he was made subject of a Hospital Order under Section 37 Mental Health Act 1983, together with a Section 41 Restriction Order, he is not to be released without the permission of the Home Secretary for public protection considerations.

For the purposes of this Executive Summary, the deceased shall be referred to as the Victim, the person responsible shall be referred to as the Perpetrator and their three children shall be referred to as S1 (daughter) S2 (daughter) and S3 (son).

The purpose of a Domestic Homicide Review, the process, details of the DHR panel, and terms of reference are contained in Appendix 1 to this report.

Summary of key Events

The Victim in this case was 73 years of age at the time of her death. She was a retired lady who was married to the Perpetrator for 43 years. The Victim and the Perpetrator had 3 children, all of whom are now mature adults and married living away from the family home. The children consist of 2 female and 1 male (S1, S2 and S3 respectively). The Victim suffered from breast cancer and had extensive treatment.

Following a career in the Merchant Navy, the Perpetrator was employed as an Engineering Manager with a well-known national company in Worcestershire. He had been there from 1982 – 1996 when he was made redundant. According to S1, this affected his mental stability; he felt rejected and didn't work in engineering but had another job for 12 months. He then retired. Their children, 2 daughters and a son, now have families of their own, the son living and working in the United States.

At the time of her death, the Victim worked for a voluntary organisation in a local hospital. In 2007 the Victim underwent surgery for breast cancer.

The Perpetrator and Victim first came to the notice of the Police in July 2000 when they responded to a domestic incident between the couple. Neighbours could hear arguing and the Victim repeatedly saying 'no'. Officers found this to be a domestic argument and took no

further action other than to send the Perpetrator and the Victim information about support following domestic incidents. The Police were not involved again until a similar incident 13 years later.

Towards the end of 2011 the Perpetrator visited his GP who raised concerns about his mental state. In January 2012 the Perpetrator again saw his GP who considered that it was time to refer him to the Early Identified Dementia Services (EIDS) dealing with people who are in the very early stage of dementia.

In February 2012 the EIDS Nurse made a home visit and it was reported that the Perpetrator's cognitive ability had gradually declined over the previous 2 years, and during this period he had showed signs of repeating questions, an inability to sustain conversations and a disorientation of the aspects of time. Despite these symptoms the EIDS Nurse was told that the couple regularly went to Spain for several weeks every year and that the Perpetrator, in general terms, was able to attend to his day to day activities. He was mobile and was able to drive, albeit for a limited distance within a regular route. Further journeys required the Victim to direct him.

An almost daily habit of the Perpetrator was to visit his local pubic house at lunch time and it is known that he would also drink wine whilst at home. He would smoke between 14-15 cigarettes every day.

The Victim was a very proud lady who was reluctant to discuss her private life with anyone. The family were Roman Catholic and there is no doubt that her religious beliefs were one of her motives for staying within this relationship, and also no doubt influenced her duty to stand by her husband come what may.

During February 2012, the Perpetrator was examined by a Consultant from the Older Adult Mental Health Services (OAMHS) and an assessment conducted revealed a suggestion of mild dementia. It also showed that his memory was deteriorating. He was assessed under the Care Programme Approach (CPA) and it was decided that his case was a Non-CPA.

The Mental Health Services determine that anyone in receipt of their services should have as a minimum a documented plan of care of which there are two types:

- Non-Care Programme approach consisting of a mental health assessment and a care plan which is a brief and concise document of care often written in a narrative document, or,
- Care Programme Approach Care Plan

During June and July the EIDS Nurse had regular contact with the Perpetrator but on 26th July 2012 she saw the Perpetrator at home on his own. He explained that the Victim had forgotten that the Nurse was coming and she had gone out, but there were no details of where she was. S1 considers that this would be very strange as her mother would not leave her father alone for any length of time and she would always have been there when the Nurse attended. His memory continued to deteriorate during the rest of 2012.

In January 2013, the Police attended the family home for the second time to a domestic incident as described previously.

In March 2013 the Victim presented at the Emergency Department at the local hospital where she was found to have a fracture to her right wrist. She explained she had fallen and she was treated. There was no in-depth enquiry about how she had sustained the injury or

indeed how she had arrived at the hospital. There was no question raised about the possibility of domestic abuse.

In August 2013, the Perpetrator started to receive the services of an Admiral Nurse referred by the GP. At this time the Perpetrator was still categorised as a non-CPA patient but his status had never been reassessed since he was initially categorised 18 months previously. This was despite his deterioration and reported increased agitation.

A Community Psychiatric Nurse (CPN) spoke to the Victim in August 2013 and the Victim described the Perpetrator as being physically aggressive at times and he was responsible for breaking her wrist earlier that year. She told the CPN that she had

“learnt to agree with him as this helps him remain calm”

The CPN spoke to the Admiral Nurse about the Victim’s broken wrist and how it had been caused but neither of them considered that this could have possibly been caused by domestic abuse. The information was not shared by anyone else.

A team referral meeting was held a few days later where the Perpetrator's case was discussed. There is no mention in the minutes of that meeting that the wrist injury was discussed or that the Perpetrator was being physically aggressive. Both the CPN and Admiral Nurse now appreciate that these factors and the comment that the Victim learnt to agree with him should have been triggers for some positive action in relation to domestic abuse.

For the Victim’s part she was having difficulty accepting that dementia was a progressive deterioration illness and she was of the opinion that the Admiral Nurse could treat her husband and reduce his dementia.

Over the following months it is recorded that the Perpetrator’s skills had deteriorated, his irritability had decreased, and he would shout at his wife and had very little patience with his grandchildren.

In October 2013, it was suggested that the Victim, should attend a Psycho Educational Group to assist her in her understanding of dementia. She attended all of the sessions and completed the course from which she gleaned much information and a better appreciation of her husband’s illness. However, there is no record of her disclosing any information about her wrist injury or her life with her husband.

On 21st January 2014, a gas fitter attended the home address to repair the gas cooker. He considered that everything was fine between the couple.

Just before midnight neighbours of the couple were disturbed by the Perpetrator stating he couldn’t rouse the Victim and she was asleep in the chair. It was noted that he was wearing smart daytime clothes.

The neighbours went to his assistance and found the Victim on the floor in the hallway. It was clear she had been injured and the neighbours thought that she was dead. Emergency Services attended and the Perpetrator was arrested. He could give no explanation about the injuries. Subsequent post-mortem reveals significant injuries to her head, neck and face as well as fractures to her ribs and deep bruising to both her sides. It was considered that some of these injuries were much older indicating previous abuse.

The cause of death was recorded as multiple injuries including blunt head injury.

The Perpetrator was detained in a secure mental hospital until he appeared before Worcester Crown Court where after a hearing of fact, a jury concluded he was responsible for the death of the Victim but the court accepted he was unfit to plead. He again appeared before the Crown Court in January 2015 where he was made subject to a hospital order under Section 37 Mental Health Act 1983 with further restrictions for public safety under Section 41, should his release ever be considered.

Views of the family

In accordance with the Home Office Guidance the Overview Report Author has been in contact with the daughters of the deceased and Perpetrator. The family are being supported by a member of AAFDA (Advocacy After Fatal Domestic Abuse). The daughter reiterated the fact that their mother was a private person but went to great lengths to explain the history of the family from when the siblings were young. Their father is described as a strict disciplinarian and he would physically chastise any of the 3 children for minor infringements. It was described how on one occasion the brother was hit and bruised and the mother told the sisters to lie about his injury at school. The Perpetrator would often be physically violent towards the Victim when the children were young.

In a later visit to S1 in June 2015 when the contents of this and the Overview Report were considered by her, she added the fact that she considered that her father was a violent person who did not need alcohol to fuel his aggression and that he was a bully. Her view is that her father

“was not a man who became violent due to dementia. He was a violent man who got dementia.”

She went on to explain that she thought the best time of her young life was an 18 month period when her father worked away from home.

In relation to the Victim, S1 explained that she too came from a physically violent home life and that behaviour was a cultural aspect of her mother's life. While she appreciates that her mother sometimes drank to excess, she considered this was a coping mechanism and her drinking was a relatively recent part of her life. S1 added that her mother had requested a move from her male GP to a female GP within the same practice and S1 is of the opinion that if she had been allowed to change GP, which it appears that she was not, she may very well have disclosed her problems to the female GP.

Finally, in relation to the Non-CPA care plan, she is certain that neither her mother or herself or her sister ever saw a care plan in relation to her father's treatment.

On 19th June 2025, the Overview Author saw the younger daughter S2 who has some significant comments to make after seeing in detail the Overview Report. She expressed the view that in 2007 just after her breast cancer operation, the Perpetrator lost his temper and tried to strike the Victim, prevented from doing so by S1. As a result of this the Victim left home and lived with S1 for a couple of weeks before returning home to the Perpetrator.

S2 was also critical of the family GP, who she considers prevented the Victim from changing from him to a female GP to whom she was more likely to disclose her troublesome life at home. Her opinion of the report is that the GP was under represented and she was of the view that the number of times both her parents went to the GP and had blood taken for examination, the GP must have been aware of the amount they, and particularly her Father, was drinking. She wonders how the GP appeared to fail to recognise medication; alcohol and dementia did not pose a risk of violence and why something wasn't one about it. She

also ponders about a possible association that the GP and her Father had at the Roman Catholic Church, where she was aware the GP attended.

In light of these comments from the daughters of the Victim and Perpetrator, their views were shared with the GP's surgery, who was invited to comment. The surgery responded by submitting a lengthy account of treatment that had been given to both the Victim and the Perpetrator, which, with permission from the surgery, was shared with the daughters. Having had sight of the surgery's response the daughters stated that they were content with the treatment and care that their parents had received from the surgery.

Analysis and Recommendations

The Perpetrator was recorded as being a Non-CPA patient. Section 13 of the policy indicates that every Care Plan should be reviewed as a continual and collaborative process and while the Perpetrator was being seen on a regular basis by Mental Health Professionals, there is no evidence that the Care Plan was reviewed. It meant that comments by the Victim such as

“he is becoming more aggressive” and “I have learnt to agree with him”

went unheeded, whereas they should have been considered against his Care Plan.

The Safeguarding Service Manager of the Integrated Safeguarding Team, NHS Trust made a relevant and candid comment in their IMR to the effect that this failure to consider such comment meant that any risk assessment was not an accurate reflection of the current situation with the Perpetrator and did not prompt a transfer to a full care programme approach.

As already mentioned, there was a breakdown in communication between the CPN and the Admiral Nurse at the Team Referral Meeting in August 2013 when the Victim's disclosure about her wrist fracture should have prompted more positive action regarding domestic abuse.

Comments are made in some IMRs to the effect that the Victim had the opportunity to be seen alone by professionals and also had the opportunity to be seen during the Psycho Educational Group where she could have disclosed details of her problems at home.

S1 clearly points out that the reality of the Victim disclosing or even requesting to be seen alone would have sparked 'aggressive inquisitive questioning' by the Perpetrator which may have put her at risk of serious harm and this prospect was clearly not considered.

As far as the GP is concerned, records indicate that the Victim did state that the situation at home was worsening; her husband was becoming more aggressive, more agitated, argumentative, but none of these comments appeared to have triggered any reaction or enquiry about the possibility of domestic abuse.

There is no evidence that the GP's practice was complying with the Royal College of General Practitioners Guidance issued in June 2012 which states that GPs should adopt an assertive approach to enquiring with patients about the possibility of domestic abuse, that a member of the practice should be considered a single point of contact for information for patients regarding support and voluntary agencies, and all members of staff, both medical and non-medical should receive training on recognising and dealing with domestic issues. This guidance is also commensurate with the recommendations contained in the National Institute of Clinical Excellence (NICE) Guidance of February 2014.

S1's comments about the GP surgery is that her mother was seen by a female GP at that practice during her breast cancer problems, but was registered with a male GP who was dismissive of the Victim's complaint of this depression and because of that the Victim requested to be transferred to the female GP which appeared to have been rejected by the surgery. As a result, S1 considers her mother did not disclose to the male GP but probably would have disclosed to the female GP. It is stressed that these are the views of the Victim's eldest daughter and there is no factual evidence to support that.

As far as the Police action is concerned it has to be appreciated that the two incidents responded to by West Mercia Officers were 13 years apart. An examination of the action taken reveals that the incidents were correctly categorised and information leaflets delivered subsequently to the Victim and Perpetrator. It also has to be appreciated that in 2000 the recording of domestic incidents was completely different to today's procedures.

Since 2014 Warwickshire and West Mercia Police have created Harm Assessments Units (HAU) and also more recently Multi Agency Safeguarding Hubs (MASH) where such referrals will now be assessed by the Multi Agency Representatives in MASH and previous calls of a similar nature to the same people or the same address will be collated and fully assessed rather than dealing with each incident in isolation.

In addition both police forces have piloted the use of Domestic Violence Protection Notices which has now been implemented throughout each force. However, the Police IMR indicates that there is still work needed to ensure that all officers have knowledge of the DVPN process and a recommendation is made regarding this.

In addition to the changes mentioned regarding the Police processes and the implementation of the NICE guidance, work has also been undertaken to co-locate specialist Independent Domestic Violence Advisors (IDVA) who work within hospitals, especially emergency departments, midwifery and mental health departments to provide a proactive support system for those who are or potentially could be victims of domestic abuse.

The Worcestershire Forum against Domestic Abuse and Sexual Violence has worked with hospitals on various campaigns and conferences across Worcestershire and were engaged in the 'White Ribbon Campaign' during a recent 16 days of international action against domestic abuse. The Forum has also worked with Local Safeguarding Children Board regarding an e-learning professional development.

In January 2015, Worcestershire Acute Hospital NHS Trust launched a new Cancer Services Holistic Assessment Guidelines where domestic abuse features heavily.

Conclusions

There is no doubt that the Perpetrator's mental illness contributed significantly to the circumstances that led to the Victim's death. However, it is clear from evidence from his daughter that the Perpetrator was for the most part of his life an aggressive and violent person, albeit this was unknown to any agency with the exception of one incident disclosed to Worcestershire Health and Care Trust which was not recognised as need for concern,

The Victim was clearly a woman who was very private but strong willed and was reluctant to admit that her life with her husband was violent and clearly a painful process. Other than the occasional incident such as asking for shelter at the neighbour's house, there was no indication outside the immediate family of any problems between the Victim and the Perpetrator. Police attended on 2 occasions two minor domestic arguments, one if not both of those incidents fuelled by alcohol. It was known that both the Victim and the Perpetrator

would drink alcohol, but according to the family, alcohol was not needed for the Perpetrator to abuse the Victim or take unpredicted extreme action against her. To an outsider they seemed to be a reasonably happy married couple who enjoyed long periods of holiday abroad each year.

It is clear now that as his dementia deteriorated, life was becoming more difficult for the Victim. She visited the GP on numerous occasions alone and again this would have afforded her the opportunity to disclose if she wished. However, the GP did not pro-actively ask questions regarding Domestic Abuse or consider that any violent behaviour thought to be a symptom of his dementia, was in fact a progression of what we now know was existing violence. The Victim wanted to change GPs to a female GP and it is the opinion of the daughter S1 that the Victim would have disclosed to the female GP had she been given the opportunity to change.

This was the same for the CPN who did not make the links to DA albeit, in this case, the Victim did disclose DA. There appeared to be a lack of knowledge regarding connecting violent behaviour associated with dementia to domestic abuse. There is much research that focuses on the dementia sufferer as being more likely to be the victim of DA rather than the carer being the victim.

These comments should have been explored further. They should have raised concerns especially given the known facts, signs and symptoms surrounding the deterioration of dementia patients, which often includes increased aggression at the very least.

The role played by alcohol or drug misuse in domestic violence and abuse is poorly understood. Research has indicated that 21% of people experiencing partner abuse in the past year thought the perpetrator was under the influence of alcohol and 8% under the influence of illicit drugs (Smith et al. 2012)¹.

Had all the above comments been recognised, additional support may have been available for both the Victim and the Perpetrator.

There were missed opportunities to intervene with both the Perpetrator and the Victim and to support the wider family. This may have presented opportunities to mitigate against serious harm, but the Panel are of the view, intervention may not necessarily have prevented the death of the Victim.

¹ Smith K (ed), Osborne L, River D et al (2005) Homicides, Firearm Offences and Intimate Violence 2010/11 supplementary volume 2 to Crime in England and Wales 2010/11 London Home Office

List of Recommendations

Recommendation No 1

NHS England should circulate the NICE Guidance 2014 and the RCGP 2012 guidance on Domestic Abuse to all Worcestershire GPs. NHS England and NHS Redditch and Bromsgrove, NHS Wyre Forest and NHS South Worcestershire Clinical commissioning Groups (CCGs) should support local GPs to implement guidance and offer additional training.

Recommendation No 2

West Mercia Police to confirm with Worcestershire Community Partnership within 6 months of the date of this report that information regarding the dissemination of the use of Domestic Violence Protection Notices has been completed for all officers within the force.

Recommendation No 3

Worcestershire Forum Against Domestic Abuse to review and update the Multi Agency Procedures to ensure that they are visible to professionals on the website on the 'Information for Professionals' page.

DOMESTIC HOMICIDE REVIEW

CASE No. 6

Purpose of a Domestic Homicide Review

1.2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance² on 13th April 2011. Under this section, a domestic homicide review means a review “*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

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

(b) a member of the same house hold as himself, held with a view to identifying the lessons to be learnt from the death”

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse³, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

This can encompass, but is not limited to, the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

1.2.5 Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

² Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 Amended 2013 www.homeoffice.gov.uk/publications/crime/DHR-guidance

³ Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- 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 these lessons to service responses including changes to the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.

1.3 Process of the Review

- 1.3.1 West Mercia Police notified South Worcestershire Community Safety Partnership (SWCSP) of the homicide on 21st February 2014. The Worcestershire Forum Against Domestic Abuse and Sexual Violence acting on behalf of the Community Safety Partnership convened a DHR sub group meeting and considered the circumstances as known at that stage, and decided not to hold a domestic homicide review. A letter was sent to the Home Office to this effect on 18th June 2014. The Home Office replied that there should be a review and the sub-group of the SWCSP met on 8th July 2014 and commissioned a DHR. The Home Office were informed on 10th July 2014 of the intention to commission a DHR.
- 1.3.2 An independent person was appointed to chair the DHR panel and to be the author of the overview report.
- 1.3.3 Home Office Guidance⁴ requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review.

1.4 Independent Chair and Author

- 1.4.1 Home Office Guidance⁵ requires that;
“The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant”, and “...The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review.”
- 1.4.2 The Independent Chair and Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has many years’ experience in writing over 80 Serious Case Reviews and chairing that process and, more recently, performing both functions in relation to Domestic Homicide Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

⁴ Home Office Guidance 2013 page 15

⁵ Home Office Guidance 2013 page 11

1.5 DHR Panel

1.5.1 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Members of the panel and their professional responsibilities were:

Martin Lakeman	Worcestershire County Council Domestic Abuse Co-ordinator
Tom Currie	National Probation Service West Mercia
Damian Petitt	West Mercia Police
Ellen Footman	Designated Nurse Safeguarding Worcestershire
Karen Reese	Worcestershire Health and Care Trust
Sarah Cox	Worcestershire County Council Quality & Safeguarding Services Manager
Lyn Mills	Worcestershire County Council Health and Wellbeing (Administrator)

1.5.2 None of the Panel members had direct involvement in the case, nor had line management responsibility for any of those involved.

1.5.3 The Panel was supported by the DHR Administration Officer, Lyn Mills. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

1.5.4 The full Panel met on three occasions and the Author, Domestic Abuse Co-ordinator and Administrator met on an additional two occasions. At an IMR Authors' briefing the Co-ordinator invited an expert on dementia from the University of Worcester and a senior member of staff from Accident and Emergency. Together they were able to enlighten the Panel regarding the effects of dementia on individuals and families as well as the developing problems the carers face as dementia progresses.

1.6 Parallel proceedings

1.6.1 The Panel were aware that the following parallel proceedings were being undertaken:

- Her Majesty's Coroner opened an Inquest on 23th January 2014 and on 7th July 2014, he adjourned the Inquest to a date to be fixed. Following the criminal trial HM Coroner closed the Inquest on 12th January 2015 recording 'not resumed after criminal proceedings'.
- The DHR Panel Chair advised HM Coroner on 21st July 2014 that a DHR was being undertaken, and the Coroner has been updated on a regular basis.
- The review was commenced in advance of criminal proceedings having been concluded and therefore proceeded with an awareness of the issues of disclosure that may arise.

1.7 Time Period

1.7.1 It was decided that the review should focus on the period from 1st July 2000 (the time the Perpetrator first came to the notice of the police) to the date of the Victim's death on 20th January 2014.

1.8 Scoping the review

- 1.8.1 The process began with a scoping exercise by the panel to identify agencies that had involvement with the Victim and Perpetrator prior to the homicide. Where there was no involvement or significant involvement by agencies the panel were advised accordingly.
- 1.8.2 Agencies were asked to identify any other significant information that may add to an understanding of the quality of dynamics of the relationships within the family before and after the time period.
- 1.8.3 The purpose of the extended period is to examine and identify what opportunities were available for agencies to intervene or challenge decisions that were made in respect of the Perpetrator and their adult children by parents where concerns may have been escalated by agencies.

1.9 Individual Management Reviews

- 1.9.1 The following agencies were requested to prepare chronologies of their involvement with the Victim and her family, carry out individual management reviews and produce reports:
- West Mercia Police
 - Worcestershire Acute Hospitals Trusts
 - Worcestershire County Council Adult Social Care

1.11 Terms of Reference

- 1.11.1 The Terms of Reference for this DHR are divided into two categories i.e.:
- the generic questions that must be clearly addressed in all IMRs; and
 - Specific questions which need only be answered by the agency to which they are directed.
- 1.11.2 The generic questions are as follows:
1. Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
 2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
 3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?
 4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?
 5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
 6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
 7. What were the key points or opportunities for assessment and decision making in this case?
 8. Do assessments and decisions appear to have been reached in an informed and professional way?

9. Did actions or risk management plans fit with the assessment and the decisions made?
10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and in what way, were the victim's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the victim should have been known?
13. Was the victim informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the perpetrator? For example, were they being managed under MAPPA?
16. Had the victim disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?
23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
24. How accessible were the services for the victim and the perpetrator?
25. To what degree could the homicide have been accurately predicted and prevented?

1.11.3 In addition to the above, the following agencies are asked to respond specifically to individual questions:

- Worcester Health and Care Trust
 - Was the Mental Health Care Programme approach (CPA) Policy followed and were the decisions made about the care programme approach used in line with this policy?
 - What assessments of the Perpetrator's mental capacity were undertaken and at what stage? How did these assessments, if undertaken, inform assessments, risks and actions?
 - Is there evidence that appropriate care assessment was made and offered?
 - Was the victim spoken to alone as part of any assessment?
- Worcestershire NHS Acute Trust
 - Was the victim spoken to alone as part of any assessment?
- NHS England
 - What assessments of the Perpetrator's mental capacity were undertaken and at what stage? How did these assessments, if undertaken, inform assessments, risks and actions?

- Is there evidence that appropriate care assessment was made and offered?
- Was the victim spoken to alone as part of any assessment?
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1.11.4 On 3rd September 2014 the Overview Report Author visited family members who were in the company of a representative of AAFDA (Advocacy After Fatal Domestic Abuse) who requested consideration be given to amending the Terms of Reference to read

“This review seeks to examine the circumstances surrounding the tragic death of the Victim at the hands of her husband following a long history of domestic abuse. It also seeks to examine the interaction between agencies involved.”

1.12 Individual Needs

1.12.1 Home Office Guidance⁶ requires consideration of individual needs and specifically:

- “Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the Victim, the Perpetrator and their families? Was consideration for vulnerability and disability necessary?”

1.12.2 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

1.12.3 The review gave due consideration to all of the Protected Characteristics under the Act. 1.12.4 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

1.12.4 The perpetrator and the Victim are white European Roman Catholics. The Victim had suffered breast cancer and was under the care of a Breast Care Nurse. They were both pensioners in their 70's.

1.13 Lessons Learned

1.13.1 The Review will take into account any lessons learned from previous Domestic Homicide Reviews as well as Child Protection and Adult Safeguarding reviews and appropriate and relevant research.

1.14 Media

1.14.1 All media interest at any time during this review process will be directed to and dealt with by the Chair of the South Worcestershire Community Safety Board.

1.15 Family Involvement

1.15.1 Home Office Guidance⁷ requires that:

⁶ Home Office Guidance page 25

“members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim’s experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator’s networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances”, and:

“Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide.”

- 1.15.2 The views of the family members and any family friends identified by the family will be taken into consideration. The family members will be invited to participate in the review process. (See section re Views of the Family)
- 1.15.3 These Terms of reference were considered a standing item on Panel Meetings agendas and will be constantly reviewed and amended according as necessary.

Bibliography

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

Home Office 2011 Amended 2013

www.homeoffice.gov.uk/publications/crime/DHR-guidance

Homicides, Firearm Offences and Intimate Violence 2010/11 supplementary volume 2 to Crime in England and Wales Smith K (ed), Osborne L, River D et al (2005 2010/11)

London Home Office