Domestic Homicide Review Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Judith
in August 2017

Report Author: Christine Graham
January 2019

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this review and the process and timescales of the review.

Section 2 of this report will **set out the facts** in this case **including a chronology** to assist the reader in understanding how events unfolded that led to Judith's death.

Section 3 will provide **overview and analysis of the information** known to family, friends, employers, statutory and voluntary organisations and others who held relevant information. It will specifically address the issue of identifying any **domestic abuse** that existed within couple's the relationship.

Section 4 will address **other issues** considered by this review

Section 5 will set out the lessons learned in the review

Section 6 will provide the **conclusion** debated by the Panel and **Section 7** will set out the **recommendations that arise.**

Appendix One provides the **terms of reference** against which the panel operated

Where the review has identified that an opportunity to intervene has been missed, this has been noted in a text box.

Preface

Bassetlaw, Newark and Sherwood's Community Safety Partnership wishes at the outset to express their deepest sympathy to Judith's family and friends, particularly to children who survive her. This review has been undertaken in order that lessons can be learned; we appreciate the support and challenge from families and friends throughout the process.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this homicide in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by the Bassetlaw, Newark and Sherwood Community Safety Partnership on receiving notification of the death of Judith in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Glossary

DASH	Domestic Abuse, Stalking and Honour based violence risk assessment model introduced to all UK police forces since 2009
DHR	Domestic Homicide Review
ICDS	Integrated Children's Disability Service
IDDS	Intellectual and Development Disability Service
IMR	Individual Management Review – this is a review undertaken by an organisation to look at their interaction with the victim or perpetrator and identify good practice or lessons learned

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Section One – Introduction

1.1 Summary of circumstances leading to the review

1.1.1 At just after 5pm on a Wednesday afternoon in August 2017 Frank called Nottinghamshire police. In the call he reported that he had killed his partner at their home in a Nottinghamshire market town. He asked for police to go to the couple's home as he had left his disabled child there alone. He said he had left the address and was making his way to the police station.

1.1.2 Officers attended the address and found the couple's disabled child in the living room. Judith was lying face down on the sofa in the same room having suffered multiple stab wounds to her body and blunt trauma to her head. Despite efforts of the officers initially on the scene and paramedics who arrived later, Judith was pronounced dead.

1.1.3 During this time, Frank was still on the telephone to the police control room and told them he was walking in the direction of the police station. Officers located him in the street and arrested him on suspicion of murder.

1.1.4 During the journey to the custody suite, his examination by the doctor in custody as well as during interviews by police, Frank admitted killing Judith.

1.1.5 Frank was charged with Judith's murder and pleaded guilty to manslaughter on the grounds of diminished responsibility. The court accepted that at the time of the homicide Frank was suffering a depressive illness that severely impaired his reasoning resulting in temporary loss of self-control. In August 2018 he received a prison sentence of 9 years and 4 months.

1.1.6 An inquest was opened into Judith's death and was adjourned pending the outcome of the criminal proceedings. Following the completion of those proceedings, and after consultation with the victim's family, HM Coroner formally closed the case.

1.1.7 This review has sought to identify the factors that resulted in the death of Judith at the hands of Frank. Specifically, it has exhaustively sought to identify whether prior domestic abuse existed within the relationship and, if so, to find that trail of abuse. What has become clear is that tension existed between the couple over a fundamental difference of views relating to their child's care. This, coupled with an increasing depressive illness in Frank and his reluctance to address his mental health issues, led to what was accepted by all the psychiatric assessments undertaken after the homicide as the aforementioned temporary loss of self-control.

1.2 Reasons for conducting the review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

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

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case, Frank has been found guilty of the manslaughter of Judith. Therefore, the criteria have been met.

1.2.4 The purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- 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 policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.3 Process and timescales for the review

1.3.1 Bassetlaw, Newark and Sherwood Community Safety Partnership were notified five days after the death.

1.3.2 A partnership meeting was held on 13th October 2017 after an initial trawl had been undertaken to ascertain those agencies with knowledge of the family. This meeting was chaired by the Chair of the Partnership and the decision was taken to appoint an independent chair and report author and proceed with a DHR.

1.3.3 The Independent Chair and Report Author were appointed on 13th November 2017.

1.3.4 The Home Office were notified of the decision to carry out a DHR at the beginning of December 2017. The family were notified of the intention to hold a review.

1.3.5 The first panel meeting was held on 24th January 2018. The following agencies were represented at this meeting:

- Bassetlaw District Council
- Bassetlaw, Newark and Sherwood Community Safety Partnership
- Newark and Sherwood District Council
- Nottinghamshire County Council – Adult Services
- Nottinghamshire County Council – Children's Services
- Nottinghamshire Healthcare Trust
- Nottinghamshire Police
- Nottinghamshire Women's Aid

- SFHT – Sherwood Forest Hospital Trust

Apologies were received from the National Probation Service.

1.3.6 At this first meeting, the panel considered its composition and agreed that it brought together the relevant expertise in relation to the circumstances of this case.

1.3.7 It was agreed that Individual Management Reviews (IMR) would be requested from:

- Nottinghamshire Police
- Children's Social Care
- GPs
- Community Services
- Intellectual Disability Services

1.3.8 All IMRs were completed by those who were independent of any involvement with the subjects of this review.

1.3.9 The panel met three times and the review was concluded in January 2019.

1.4 Confidentiality

1.4.1 The content and findings of this review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2 To protect the identity of the deceased, their family and friends, Judith will be used as a pseudonym to identify the deceased hereafter and throughout this report. The person who killed her will be known as Frank.

1.5 Dissemination

1.5.1 The following individuals/organisations will receive copies of this report:

- Judith's family
- Frank's family (a copy of the report will be provided to the prison in order that this can be shared with Frank and he can be supported as he reads it)
- Nottinghamshire Police and Crime Commissioner
- Chief Constable, Nottinghamshire Police
- Chief Executive, Newark and Sherwood District Council
- Director for Children's Services, Nottinghamshire County Council
- Head of Services, Nottinghamshire Women's Aid
- Chief Executive Officer, NHS Newark and Sherwood Clinical Commissioning Group
- Chair, Nottinghamshire Health and Wellbeing Board
- Independent Chair, Nottinghamshire Safeguarding Adults Board
- GP practice for Judith and Frank
- Senior Coroner for Nottinghamshire

1.6 Methodology

1.6.1 Bassetlaw, Newark and Sherwood Community Safety Partnership was advised of the death by Nottinghamshire Police five days after the death. This was a timely notification and demonstrated a good understanding by the police of the need for a referral at the earliest opportunity.

1.6.2 In response to the notification, a partnership meeting was held on 13th October 2017. This was chaired by the Chair of the Community Safety Partnership. At this meeting, the police provided a summary of the homicide and those partners present shared the initial information that they held in relation to Judith and Frank. At this meeting it was clear that whilst the couple were known to services in relation to their child and their previous role as foster carers, there was nothing in the records of agencies to indicate any domestic abuse in the relationship.

1.6.3 Having heard the contributions from the partners present, the Chair took the decision to hold the Domestic Homicide Review because it was clear that, given the information available at the time, there would be learning from this case. The Home Office was informed of the decision to undertake the review. This decision demonstrates a good understanding by the Chair of the Partnership of the issues surrounding domestic abuse and a willingness to welcome external scrutiny of the case in order that lessons could be learnt.

1.6.4 Gary Goose and Christine Graham were appointed in November 2017 to undertake the review and the Review Panel met for the first time on 24th January 2018. The Panel met three times and the final meeting of the Panel was on 9th January 2019.

1.6.5 At the meeting on 24th January 2018 all members of the panel were present with apologies from the National Probation Service. At this meeting, the process of the Domestic Homicide Review was explained to the panel with the Chair stressing that the purpose of the review is not to blame agencies or individuals but to look at what lessons could be learned for the future. Prior to this meeting, the Chair had met with the police's senior investigating officer (SIO) to ensure that Section 9 of the statutory guidance was adhered to. As Frank had admitted the offence, it was agreed that the review could proceed ahead of the sentencing hearing.

1.6.6 Agencies were asked to secure and preserve any written records that they had pertaining to the case. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.6.7 At this meeting the Terms of Reference were agreed subject to the family being consulted. It was agreed that the Chair and Overview Report author would make contact with the family with an introduction via the police family liaison officers.

1.6.8 On 25th May 2018 the Chair met with the Judith's brother and Frank's adult son. At this meeting, the family were invited to meet the panel if they wished but felt that they were happy for liaison to take place through the Chair and Report Author.

1.6.9 At the first sentencing hearing on 13th July 2018, the report author met a number of friends and family members and further contact was made following this hearing.

1.6.10 The Chair and Report Author met with Frank in prison on one occasion.

1.6.11 The Chair and Report Author have met with the family to share the report. A copy has been left with the family to allow them to read the report in peace and at their own pace.

1.7 Contributors to the review

1.7.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

1.7.2 All Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the panel or meeting for an interview.

1.7.4 The following agencies contributed to the review:

- Newark and Sherwood District Council
- Nottinghamshire Police
- Nottinghamshire County Council
- Nottinghamshire Healthcare Trust
- Newark and Sherwood Clinical Commissioning Group
- Nottinghamshire Women's Aid

1.7.5 The following individuals contributed to the review:

- Family of Judith and Frank
- Close friends of the Judith and Frank

1.8 Involvement of family and friends

1.8.1 The Chair and Report Author, both together and separately, met with a number of members of the extended family of Judith and Frank. The family came together for a meeting with the Chair and Report Author when the report was shared.

1.8.2 Judith's brother met with the Chair as did close friends of Judith and Frank, who had known Judith before she met Frank.

1.8.3 Frank's adult child was also contacted, and the review respects their wishes to not be directly involved in the review but was kept informed by family members.

1.8.4 All those spoken to were informed about the support available through AAFDA[1].

1.9 Review Panel

1.8 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Ros Theakstone	Director of Corporate Resources	Bassetlaw District Council
Ben Adams	Community Safety Manager	Newark and Sherwood District Council
Nicolette Richards	Domestic Abuse Officer	Newark and Sherwood District Council
Justine Wilson	Detective Chief Inspector	Nottinghamshire Police
Clare Dean	Detective Chief Inspector	Nottinghamshire Police
Tina Hymas-Taylor	Head of Safeguarding	Sherwood Forest Hospital Trust
Naomi Russell	Group Manager, Younger Adults, Bassetlaw Newark & Sherwood	Nottinghamshire County Council
Joe Foley	Children's Services Manager	Nottinghamshire County Council
Sally Cope	Group Manager Younger Adults South Nottinghamshire	Adult Social Care Nottinghamshire County Council
Julie Gardner	Associate Director Social Care	Nottinghamshire Healthcare Trust
Mandy Green	Head of Services	Nottinghamshire Women's Aid
Hannah Hogg	Corporate Safeguarding Lead	Nottinghamshire Healthcare NHS Foundation Trust
Sue Barnitt	Head of Quality and Adult Safeguarding	Newark and Sherwood Clinical Commissioning Group

1.10 Domestic Homicide Review Chair and Overview Report Author

1.10.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October

[1] Advocacy After Fatal Domestic Abuse

2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.10.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. Christine also delivers Partnership Health checks which provide an independent view of partnership arrangements. Christine is also a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews.

1.10.3 Working together, Christine and Gary have completed four reviews, with sixteen reviews (excluding this one) currently in progress. In addition, Gary has completed six reviews working alone.

1.10.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[2]

1.10.5 Both Christine and Gary have:

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports
- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended the AAFDA Annual Conference (March 2017)
- Attended training on the statutory guidance update in 2016
- Undertaken Home Office approved training in April/May 2017
- Attended the AAFDA Annual Conference (March 2018)
- Attended Conference on Coercion and Control (Bristol June 2018)
- Attended AAFDA Learning Event – Bradford September 2018

1.11 Parallel Reviews

1.11.1 Other than the aforementioned criminal justice and coronial processes, no other inquiries were conducted into the circumstances of this case.

1.12 Equality and Diversity

1.12.1 Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

- Race
- Religion or belief
- Sex
- Sexual orientation

1.12.2 Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[3] Women are more likely than men to be killed by partners/ex-partners. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[4]

1.12.3 The Panel is mindful of the fact that Frank is from a minority ethnic group. Frank is of dual heritage, with his father being Pakistani and his mother being white British. Frank's family are Pakistani. He was Muslim by birth but was 'Western-ised'. It is important, however, to acknowledge that Frank considers himself to be dual heritage. English was his first language and he could barely speak his native tongue.

1.12.4 Frank was deaf and did not wear hearing aids. His family all said that this meant that he was prone to shout and appear aggressive because he did not realise how loud he was. There is nothing to suggest that this had an impact on his relationship with Judith.

1.12.4 It is important to note that Frank and Judith were caring for a severely disabled child. The impact that this would have had on them is explored within the report.

3 (Women's Aid Domestic abuse is a gendered crime, n.d.)

4 (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)

Section Two – The Facts

2.1 Introduction

2.1.1 Judith was a white British woman and Frank was of dual heritage (his father being Pakistani and his mother being white British). They had been in a relationship for 30 years. At the time of her death Judith was 59 years old. She had one brother. They had one child with profound and multiple learning difficulties. Frank was 58 years old at the time of the homicide. He had two children from an earlier marriage, one of whom had lived with Frank and Judith and considered Judith to be their mother.

2.1.2 The couple had been foster-carers for a number of years fostering many children over the years until they decided to withdraw from the service in 2009. Many of those fostered by Judith and Frank were teenagers presenting with very difficult behavioural issues and learning disabilities. The couple remained in close contact with a good number of them. There is no doubt that both Judith and Frank contributed hugely to the lives of others. Judith's brother described them as a 'formidable team' who had left a great legacy in the restored lives of many teenagers.

2.1.3 A full chronology of events and a summary of information known by family, friends and agencies will follow within this report.

2.2 Chronology

2.2.1 **Background information**

2.2.2 Judith had grown up in South London and had discovered Christian faith in her teens. Her brother described how, following this, she became a fighter for social justice, prioritising those who were marginalised.

2.2.3 Frank was a miner and had been in a relationship with Judith for the past 30 years. They met when he was collecting for the striking miners in London during the national miner's strike of 1983/84. At the time, he was married with children.

2.2.4 Together they had one child who had profound and multiple learning difficulties. She required full time care and lived at home with Judith and Frank. At the time of the homicide, she had recently transferred from children's services to adult disability services, having reached the age of 18. The part that caring for her and this transition played in the weeks and months leading up to the homicide are pertinent and therefore will be discussed in more detail within this report.

2.2.5 Judith and Frank had been foster-carers since 1991 and looked after a number of children, many of whom remained in contact with the couple. They ceased being foster carers in 2009. One of the children that they fostered died whilst in their care from natural causes. The death affected both Judith and Frank significantly and Frank has told this review that it left some degree of enduring anxiety and minor tension between them as they differed over the care provided to the child in the minutes prior to his death. There were no other notable issues that require mention within this chronology until the months leading up to the homicide that will now be dealt with separately.

2.2.6 **The months leading up to the homicide**

2.2.7 The transition of their child from children's social care to adult social care was of increasing concern to the couple as the time approached for her to leave the schooling provided which occupied a significant proportion of her time. The family were referred to the Transitions Team (Nottinghamshire County Council) in September 2015 in order that arrangements could be made for their child's transfer when she became 18.

2.2.8 In April 2016 a carer's assessment was undertaken for both Judith and Frank and arrangements for visits to a short break unit were made.

2.2.9 The final overnight short break review was undertaken by Integrated Children's Disability Service (ICDS part of Nottinghamshire County Council) on 12th May and a visit was then made to Wynhill short break unit on 16th (for Judith and Frank) and 27th May 2016 (with their child) organised by Adult Social Care.

2.2.10 On 7th June 2016 a Transitions Team case summary was completed, and it was noted that Frank and Judith were unsure about their future plans for their child. Following this an assessment was completed. On 28th July the social worker raised the case in supervision saying Frank and Judith were unsure about a referral to adult short break.

2.2.11 In August 2016 Frank attended his GP due to stress and trouble sleeping. According to his GP records, he did not have any thoughts of deliberate Self Harm and was prescribed with short term medication to be taken as needed. Frank's recollection of this consultation is that he told the GP that he was feeling suicidal.

2.2.12 Frank was reviewed by the GP on 15th September but there is nothing in the records to suggest that the previous concerns about stress were discussed by the GP or raised by Frank.

2.2.13 On 19th September 2016 their child made her last visit to Minster View, this was shortly before her 18th birthday.

2.2.14 On 12th October an email was sent to Frank and Judith, as the social worker had been unable to make contact with them, to enquire about their thoughts about future support plans for their child.

2.2.15 On 24th November 2016 it was noted in the supervision notes of Intellectual and Development Disability Service (IDDS), provided by Nottinghamshire County Council, that they did not wish a short breaks referral to be made for their child.

2.2.16 On 25th November 2016 a case note alert was sent to the IDDS to discuss adult support options with the family.

2.2.17 At some point at the beginning of 2017 (which is not clear) Frank and Judith's child received an additional diagnosis of Autistic Spectrum Disorder.

2.2.18 On 16th March 2017 a supervision note in IDDS queried about adult short breaks for Frank and Judith's child when she leaves school in September 2017.

2.2.19 In July 2017 Judith, Frank and their child all holidayed on an island in the Scottish Highlands with two other couples who they had known for many years. Frank is described by all as

being in low mood and becoming obsessed with minor issues. This was so noticeable that Judith and the friends discussed together the best way of approaching Frank about it. One of the closest friends travelled back from holiday with Frank and asked him about it when staying with him overnight at another family member's home.

2.2.20 Frank attended his GP on 1st August 2017. The GP recorded that Frank stated that he was experiencing increasing anxiety, night time waking and was 'a bit low in mood' and again he said he had no thoughts of deliberate Self Harm. Frank's recollection of this consultation is that he told the GP he was feeling worse than he ever had before.

2.2.21 Frank was seen by the same GP a week later when he said he had not been taking his diabetic medication for a long time due to anxiety. He was advised to recommence his medication.

2.2.22 On 8th August 2017 IDDS recorded in their files that their child was going to Portland College in September 2017 and that the Transitions Team were to consider day services and any other additional adult services that she would need.

2.2.23 **The day of the homicide**

2.2.24 Just after 5pm Frank dialled 999 and reported that he had killed his partner. During this call he confirmed that she was dead, saying that he had waited until she had died before he had called. He asked the 999 operator to get the police to go to the house as he had left his disabled child there alone. During this call he said he would make his way to the police station.

2.2.25 Having begun the call he walked in the direction of Newark Police Station. Officers attended the address where they found their child in the living room and Judith was lying face down on the settee. No pulse was found, and CPR was commenced. Paramedics arrived and despite their efforts, Judith was pronounced dead. A rolling pin and knife, both covered in blood, were found in the lounge area.

2.2.26 Frank remained on the telephone during this time and officers located him in the street and he was arrested on suspicion of murder.

2.2.27 Whilst in custody, Frank said that he had intended to kill Judith, his child and then himself but that, having killed Judith, he could not continue with the plan.

2.2.28 Following a post mortem it was concluded that Judith had received eight stab wounds to her back. Whilst these were significant, they did not directly result in her death. She also suffered multiple blunt force injuries to her head which resulted in nine lacerations and a significant skull fracture. It was noted that there were no defensive injuries to the body.

2.2.29 The Crown accepted a plea of guilty to manslaughter on the grounds of diminished responsibility. Frank had been subject to medical reports by three psychiatrists and there was consensus that at the time of the homicide he had been suffering from a depressive illness that resulted in a temporary loss of self-control.

2.2.30 At a sentencing hearing the judge ordered that he serve his sentence in prison, rather than receive a hospital order. The starting point for the sentence was 14 years' imprisonment. The judge said that given his good character and full credit for a guilty plea and his co-

operation in the investigation, this was reduced to 9 years and 4 months and he would serve half of this sentence in prison.[5]

[5] The reason for this sentence is discussed elsewhere within the report

Section 3 – Overview and analysis

3.1 Information known to family and friends

3.1.1 The review is very grateful to those who have contributed to the review. Several direct relatives of Frank and Judith, their partners, together with long standing friends of both Judith and Frank have fully engaged with the process. It has enabled us to form a picture of Judith, a woman who was loved and admired by many. Judith and Frank had been together for thirty years and therefore she was considered to be part of Frank's family. Thus, when his brothers and sister-in-law have talked about Judith and Frank they have spoken about her as if she were a member of *their* family.

3.1.2 Several members of the family, and friends of the couple have voiced concerns that they feel they could or should have done more. The circumstances uncovered by the police investigation and this Review have clearly shown that people did recognise that Frank's mood and behaviour was changing and that they DID act. Those closest took time out to speak to both Frank and Judith about it and assist in persuading Frank to seek help. There was nothing known to family and friends and nothing that they could reasonably have known by further conversation, that could have led them to intervene in a more preventative way. This Review places on record its view that this was a family who cared deeply for Judith and Frank and provided a supportive network.

3.1.3 The review has also spoken with Judith's brother who was able to provide information about her early life but accepts that he had seen little of her in recent years. Some of the friends who have engaged were close friends of Judith who knew her before she met Frank, and this has allowed us to triangulate their view with that of Frank's family. There has been consistency of views and accounts of Judith and Frank's relationship amongst all those interviewed. All have done so in an effort to understand why Judith died and to enable all to learn and better protect others in the future. All of those spoken to remain in shock at the homicide and all say they had no indication of abuse within the relationship. It has to be said that it is difficult to fully portray just how close this group of family and friends were. The level of interaction between them all and the time they spent in the company of Judith and Frank give the consistency of their views even greater credence than is available in some cases.

3.1.4 This review has also spoken with the perpetrator. He made it perfectly clear at the beginning of the meeting with him that he was fully responsible for what had occurred. He did not want anything said that in any way could suggest that Judith had contributed to her own death but remained at a loss as to why he had done what he had done. He openly discussed the relationship, the fundamental disagreement over their child's care and accepted that he had not been forceful enough in addressing his deteriorating mental health.

3.1.5 Judith has been described as 'the most loyal, caring and selfless person' that people had ever met. She always put others, especially their child, ahead of herself. She had a real sense of justice – of right and wrong. Judith was a woman who could stand up for herself and others.

3.1.6 Judith and Frank were described by all members of the family as being the ones that everyone turned to when they needed help and support. Every person we spoke to could relate a time when Frank and Judith had either had them to stay for an extended time or had gone to visit them regularly to support them through a difficult time.

3.1.7 Judith and Frank were very active. They would go out for walks and days out and often went away in their caravan, taking their child and other family and friends with them. Frank would cycle up to 60 miles and pick up litter on his many walks. They often went swimming and out for meals.

3.1.8 Everyone described Judith and Frank as being incredibly close. They did bicker and argue described in a way as some couples do in a relationship.

3.1.9 Frank was described by everyone as a very intelligent man. He was very active and managed his diabetes, until the final months before the homicide, by exercise and diet rather than taking medication. He was considered by some professionals to be verbally aggressive, but all of his family put this down to him being hard of hearing and his passion about subjects. No-one described him as physically aggressive. He was known to stand up for what he believed to be right and the review heard numerous examples of how he and Judith had advocated on behalf of the young people in their care to achieve a better outcome for them.

3.1.10 This review has benefited from speaking with a couple who holidayed every year with Judith and Frank since they first met and had known Judith before she met Frank. One of the couple had also spent holidays with Judith alone. They all last holidayed together three weeks before the homicide. This couple are amongst those who were present at the sentencing hearing and heard it said that the Judith and Frank had lost love from their marriage. They take strong issue with this and say that during their time together they displayed a closeness and intimacy that suggested they were still very much a loving and devoted couple. They were adamant that in all of the years they had known Frank and Judith as a couple there was never a hint of abuse within the relationship. Their level of friendship meant there was ample opportunity for it to be either disclosed or to give some hints, even if unintentional, that something was not right. There never was. They describe Judith's strength of character as such that they found it unbelievable to think that she would put up with any form of controlling behaviour or physical abuse. They did say that during the holiday Frank was not his normal self.

3.1.11 Family and friends were able to talk about changes that they had seen in Frank just prior to the homicide and these are discussed in more detail in section 4.2.6 when looking at Frank's mental health.

3.2 Evidence of domestic abuse

3.2.1 There were no reports of domestic abuse by Judith to any agency prior to her death. All of those who were spoken to, and records reviewed, uncovered no evidence to suggest that their relationship was in any way abusive. However, there is information uncovered during the police investigation that has led the review to examine again if there was any abuse prior to the final homicide.

3.2.2 During the sentencing hearing, reference was made to Frank having 'slapped' his first wife. Frank's sister has said that she was there when this happened, and she does not consider it to be a significant event and was prompted by an argument between her and other children in their care.

3.2.3 There is no indication within the GP records reviewed to suggest that domestic abuse was an issue in Judith and Frank's relationship. In 2012 Judith attended the GP for an appointment and during the course of the examination, a soft tissue bruise was noted.

When asked by the GP, Judith said that she did not know how this had occurred. The onward referral letter stated that she was unsure how this had occurred though reported that she had a disabled child. Given the evidence that we have seen of her lack of control of her movements it is possible that it had been caused whilst she was caring for her child.

3.2.4 As part of the police investigation, Judith's laptop was recovered, and, on this laptop, a number of recordings were found. It appears that Judith recorded programmes from the radio and made recordings of her reading to their child on the laptop. Two recordings were recovered which were made in April 2017, four months before the homicide. The first takes place whilst Judith was reading to their child and is a four-minute extract of an argument between her and Frank. The second takes place eleven minutes later and the following is an extract of this recording in which Judith is talking to her child after she has pinched her:

Judith:	'Get on the naughty step. You don't get away with hitting me and pinching me. He does; or he thinks he does'
Frank:	'I've said sorry Judith and I mean it. Yeah?
Judith:	'I don't think you do'
Frank:	'We need to detach ourselves; the arrangements together because we only wind each other up'
Judith:	'You say that constantly ….. you didn't get out of the house, did you? You said you were going out of the house to calm down'
Frank:	'I calmed down. I calmed down'
Judith:	'Oh, you think you were calm enough? I don't think you were calm enough'
Frank:	'Okay'
Judith:	'You just wanted to stay in the house, so you could physically intimidate me more; some more.'
Frank:	'I was trying to get through to you. I'm sorry Judith'
Judith	'I've tried to get through to you; that's speaking like that in front of your child and treating me the way you do in front of your child..'
Frank:	'I'm sorry. It won't happen again'
Judith:	'…. I've tried and tried to get through to you'
Frank:	'It won't happen again.
Judith:	'Oh so it's happened over the last 30 years….'
Frank:	'It will not happen again. I will tell everybody that we are separated …'

Judith: 'It's happened over the last 30 years and it's not going to happen anymore'

Frank: '…….but living in the same house, okay?'

Judith: 'No, I don't want to live in the same house as you. You shit up the kitchen; eat your own food, dirty more pots.

The argument then progresses to the state of the house, how depressing it is, Frank buying and then failing to look after a dog and other matters.

3.2.5 Despite exhaustive enquiries by the police there has not been any evidence from any source to corroborate or support the view that this argument is indicative of years of an abusive relationship. Of course, the recording stands on its own, but it stands in such stark contrast to the information provided by everyone spoken to by this review who say that whilst tensions existed at times within the marriage, there were no indications of physical abuse within this relationship and no indications of coercion or control by either party of the other[6]. We cannot know categorically the level of domestic abuse, if any, that Judith was subject to and the suggestion of ongoing domestic abuse has been difficult for the family and friends to come to terms with. Everyone that the review has spoken to has said that they never witnessed anything other than a loving relationship between Frank and Judith, apart from usual day-to-day bickering. Different people had been swimming with the family on numerous occasions and had never seen any bruises or marks on Judith. Her friends believed that their relationship was such that Judith, could and would have told them if she were experiencing abuse.

3.2.6 The defence, in their submission to the court, acknowledged that there was friction in the relationship and Frank accepted that there were times when they disagreed. He maintains that there was no physical violence. However, in the transcript, Frank accepts what Judith says. His defence said that they both had strong views about how the child's needs would best be met, fundamentally disagreeing about the use of medication. Judith objected to any form of medication whilst Frank felt that she would benefit from an appropriate use of medication.

3.2.7 Whilst the family and friends were at a loss to understand the recording, Frank gave an explanation for it. He described how he and Judith had disagreed, over many years, about the use of sleeping medication for their child. He believed that she was 'not doing right by her [child]' by withholding the medication. He had told her that he would go to the social services and tell them what was happening so, in his words, Judith made that tape as her 'insurance policy' in case he did this. This review is unable to corroborate this explanation in any way.

3.2.8 Judith's brother said, in his Victim Impact Statement, that the recording was hard for him to come to terms with, but it seems that Judith, like his mother, remained with a man who was violent to her but that no-one will ever know. He also told the court that a few weeks before the homicide Judith made contact with him saying that she needed to talk to him about something. He said that whilst he will never know what it was, he is sure that, for her to make this approach, it must have been serious. Judith's brother also told the review that,

[6] The panel has observed that Nottinghamshire organisations have a good understanding of coercion and control. Equation are commissioned to deliver training across the county. Nottinghamshire Police was also one of the first police forces to prosecute for coercion and control.

many years previously, his mother had told him that Judith had said that 'it looks like I've married someone the same'. At the time, he had assumed that she was referring to the fact that their father was lazy and selfish. He did not immediately associate this comment with violence and abuse. It should be noted that other members of the family have told the review that Judith had said why she was keen to speak to her brother and it was an unrelated matter.

3.2.9 When the police analysed Judith's laptop, they also found on the laptop was one Google search for 'domestic violence' but the police were unable to ascertain who had undertaken this search or for what reasons. Judith's closest friend immediately provided an explanation for this. He said that Judith was supporting someone (providing the specific details of who) and had looked up the information to share with her. They said that there was nothing more sinister than this.

3.2.10 A number of family and friends of the couple have made reference to the fact that Judith was strongly against any form of domestic violence and would be the first to condemn anyone who was responsible for this. All say she would have confronted any abuse aimed at her. That is, of course, their view. The absence of reports to agencies and the absence of mention to friends and family does not, of itself, support or corroborate that view but neither does it undermine it. It is not unusual for victims not to disclose to close friends or family for a number of reasons. This can include shame, embarrassment, fear of the reaction of family and friends for a respected member of the community and fear of not being believed. In this case, we simply do not know.

3.2.11 The evidence that prior domestic abuse existed within this relationship thus remains inconclusive. Despite all the enquiries made by police and the additional work carried out by this review, no information has been obtained to support the very stark inference heard in the aforementioned recording. Frank killed Judith, an inescapable fact and the most final of all acts of domestic violence; it could be argued that this in itself is evidence that supports its content. However, all of the avenues that can be normally expected to provide the real context of a relationship add nothing to that point of view.

3.3 Detailed analysis of agency involvement

The chronology sets out in Section 2 details about the information known to agencies involved. This section summarises the totality of the information known to agencies and others involved during the years leading up to the homicide. The detailed chronology will not be repeated here; rather this section will provide an analysis of agency involvement.

3.3.1 Nottinghamshire County Council – Fostering Service

3.3.1.1 Judith and Frank were foster carers for a significant period of time and it is reasonable to conclude that this impacted upon their family dynamics. For this reason, the Fostering Service were asked to complete an IMR.

3.3.1.2 Frank and Judith were approved as foster carers for Nottinghamshire County Council in September 1991 (seven years before their child was born) until March 2009. They were approved as foster carers for up to two children or sibling group for ages 11 and 16 plus, with a specific matching criteria with Black and Ethnic Minority children.

3.3.1.3 During their fostering career, they had approximately 16 children/young people placed in their care. Periods of placement varied from short term, time limited placements to long term placements. Three placements were long term into adulthood. Frank and Judith remained in contact with some of their foster children at the time of the homicide.

3.3.1.4 When the historic case files were interrogated there were 26 separate incidents of concern between 1993 and 2007 in relation to Frank. These were recorded as being centred around Frank's attitude to staff members including those from the fostering service, court service, child care social workers and school staff. It is recorded that issues raised were in relation to Frank being 'angry', 'rude', 'aggressive', and 'intimidating' in responses to staff members. On one occasion, in June 2002, Frank allegedly pointed a finger into the face of a senior social worker and a court official had to intervene.

3.3.1.5 In August 2006, the Children's Service Manager wrote to Frank advising that he was no longer to have contact with the allocated child care social worker due to his aggressive behaviour.

3.3.1.6 A review of the case files indicates that the concerns were only in relation to Frank and there were no such concerns about Judith.

3.3.1.7 The historic case files do not raise any concerns about the nature or quality of the relationship between Judith and Frank.

3.3.1.8 The case files document two 'Informal Complaints Meetings' which were called as a result of Frank's perceived inability to work positively with professionals and his aggressive attitude. These meetings resulted in some improvements in working with professionals, but this was never sustained.

3.3.1.9 It is noted that, at no point, was Judith seen on her own which would have allowed her to raise any concerns that she might have had about Frank.

3.3.1.10 Positive comments on the case files about the standard of care provided by Judith and Frank.

When considering how these concerns about Frank were dealt with, the review is very mindful that it is scrutinising practice of some 10-20 years ago. Practice has, in that time, moved on and the review is satisfied that now:

- **The current 'Mosaic' system has a clear place for recording and updating any concerns and allegations**
- **These concerns are updated and reviewed annually as part of the foster carer's annual review**
- **A Practice Guidance for Concerns and Allegations is now in place and is used by the Fostering Service to address any concerns or allegations at all levels**
- **It is an expectation within the Fostering Service that foster carers will be supervised jointly and also separately. This is reviewed annually as part of the annual review process for foster carers**

The review has not made any specific further recommendations for the Fostering Service.

3.3.2 Nottinghamshire County Council – Integrated Children's Disability Service in partnership with Adult Social Care and Health

3.3.2.1 The family were known to this service as they provided overnight short breaks for their child. She was entitled to 24 nights per year. The purpose of these breaks was to provide respite for her parents from their significant parental/caring duties and to provide an opportunity for young people with significant disabilities to interact with their peers and experience social activities.

3.3.2.2 The staff at the respite home describe her as a 'happy, happy girl' who appeared to enjoy her stays.

3.3.2.3 In March 2016, she was assessed with a view to considering the support that would be offered once she reached the age of 18 and transferred to the adult service. It was agreed at this meeting that carers' assessments would be provided for both parents and that short breaks would be explored, along with plans for further education and befriender and day services. It was noted in a Transitions case summary in June 2016 that her parents were unsure about future college, day services or a personal assistant for her. It was noted that Frank had some reservations about the short break units due to her vulnerabilities and Judith had said that he would require 'some talking round'.

3.3.2.4 In September 2016 it was agreed that the social worker would contact the family to check on their views about the short break referral. As the family could not be contacted, a letter was sent and November 2016 it is noted that Frank did not wish the short breaks referral to be made. It should be noted that, it is the view of the family that both Judith and Frank shared these reservations.

3.3.2.5 The Transitions Team Manager has confirmed that every effort was made to maintain contact with the family throughout this period. There were no concerns about the home situation and officers were confident that the family were positively involved in their child's support. They were also confident that the family knew how to access support. It was thought that their lack of contact was possibly due to them considering other adult support options available to them.

3.3.2.6 From the records, it appears that this situation was kept under review and in August 2017 it was noted that their child was to attend Portland College in September 2017. The transitions team were also to review to consider if any day service provision or additional adult services were needed.

3.3.2.7 In preparing their IMR for this review, the service acknowledged that transition from children's services to adult services can be a challenging time for parents and young people especially for those, like Frank and Judith's child, who have spent a considerable amount of time in familiar settings.

The review is satisfied that:

- **A timely referral was made to the Transitions Team and that assessments were carried out by Adult Services in advance of Children's Services support ending**
- **A Care Act 2014 assessment for Judith and Frank and their child was undertaken prior to her 18th birthday and in line with the Transitions protocol**

- **Because there had been some ambiguity from her parents around what services would be suitable for her, the Transitions Team had kept her open to their team and made regular but not frequent contact with the family**

The review is satisfied that the approach taken with the family was proportionate and appropriate given that there were no known concerns about Frank and Judith and their child and the Transitions Team had a plan to provide support for the family when they were ready. Therefore, there are no specific recommendations for the Integrated Children's Disability Service or Adult Social Care and Health Department.

3.3.3 Minster View

3.3.3.1 Minster View provided overnight short breaks for Frank and Judith's child from 2009 to September 2016. During this time, she attended 25 overnight short breaks. It is noted that, as most of the contact with her parents was via email; face to face contact with the family was limited.

3.3.3.2 Whilst Minster View witnessed no adverse behaviour between Judith, Frank and their child and had no reason to be concerned about their relationships, it was noted that her parents often forgot to bring her for her overnight stays (often they were on holiday) and often the communication between Judith and Frank was out of synch. Whilst this was not untoward, staff did comment 'do they not talk to each other?'. This comment was in relation to basic arrangements and knowledge of information about their child.

3.3.3.3 It is important to note that there was nothing to indicate any lack of care, neglect or concerns about domestic abuse.

The review is satisfied that there are no lessons or specific recommendations for Minster View.

3.3.4 Nottinghamshire County Council – Education Department

3.3.4.1 As previously stated, the review considers that the family situation in which Frank and Judith lived, are pertinent to the circumstances leading up to the homicide. Therefore, an IMR was requested from the Education Department.

3.3.4.2 Frank and Judith's child's school records and the records of the Educational Psychology Service were inspected as part of the completion of the IMR and these were all found to be in good order. It was noted that the school maintained a confidential 'concerns' file for her. In this file there were three entries, two of which are in a time out of the scope of this review. It was clear to the author of the IMR that none of these incidents raised safeguarding concerns and the purpose of the file is to record confidential notes that do not subsequently escalate to a safeguarding concern.

3.3.4.3 In March 2013, a body map records a bruise over her left eye. Judith had not noticed anything, and the school judged that she had probably caused this herself as 'she will from time to time smack herself, especially if she is not wearing her glasses – and she does do this really hard'.

3.3.4.4 In July 2014 Judith reported in the home-school diary that her child had a scratch on her chest which had been noticed the evening before. It was thought to be self-inflicted and Judith had reported that she was trying to keep her nails short.

3.3.4.5 In July 2016 an entry was made into her safeguarding file by the school's healthcare assistant. The school's personal care staff had reported concerns over odour when changing her pads. The entry said, 'the odour level was VERY strong and offensive'. The HCA contacted Judith to discuss and advised a visit to the GP and a urinary tract infection was subsequently diagnosed and treated.

3.3.4.6 Her school records describe her as 'a happy carefree spirit with an immense love of music, dance and the outdoors'. The focus of her teaching and learning was to increase her self-help skills with a view to her being able to live in a supported setting. Her attendance in school was good. Both parents attended her annual reviews and Judith made regular, helpful communication with the school through the home-school diary.

3.3.4.7 In order to complete the IMR, three staff from her school were interviewed. They described both parents as being friendly and supportive and 'very devoted' to her and her needs. She was, in their view, central to the family's life. Their anxiety about her potential vulnerability in the wider world was described as appropriate as they took care to see that she was safe. Both parents were very involved in the school and were well liked. Frank had been a school governor for a few years when she was younger. He was described as a sensible and reliable member of the governing body who was remembered as being very good with other pupils. Both parents attended school events such as fundraising, coffee mornings etc. They were described by the staff at the school as a couple 'who were very together'. The school had never had any concerns about the relationship between Frank and Judith and were very shocked when they heard of her death.

3.3.4.8 The school described the home life of Frank and Judith as being an 'open door policy'. There seemed to be a number of people from the community that they supported. The home was described as often busy with friends, neighbours and professionals calling. One member of staff had seen the family at social events out of school and said she never saw any situations that gave cause for concern.

3.3.4.9 Staff noted that sleep had been a long-standing problem for Frank and Judith's child. She slept poorly and often woke in the night. This was stressful and tiring for her parents. It was reported that medical staff had been involved in discussions about appropriate medication for her.

3.3.4.10 The last contact that the school had with the family was a written request for her to be taken out of school for the last two days of the summer term so that they could go on holiday to Scotland with a group of friends and this was approved.

3.3.4.11 As part of their IMR, the education department considered two particular questions about their involvement with the family. The first was whether or not there were any signs of abuse or concerns about the family that should have prompted further investigations or action. There was no evidence found that staff had any concerns about relationships within the family. The second question was about her transition from school and children's services to college and adult services and whether the transition gave rise to strains and stresses within the family unit that could have played a part in Judith's death. The enquiries for the IMR found that a 3 day per week placement in college was secure and further work was being done to identify additional provision for the other two days. Staff at the school felt that Judith and Frank 'were not desperate for new arrangements – they seemed to always

have a busy family life planned with outings and holidays for her'. The IMR suggests that there was nothing to indicate that the transition was 'off-track'.

The review is satisfied that Frank and Judith's child's educational needs seem to have been provided appropriately within Children's Services. Frank and Judith had a good working relationship with the school and contributed positively to her development and school life. No specific recommendations are made for education services.

3.3.5 Newark and Sherwood CCG

3.3.5.1 Judith, Frank and their child had all been registered with the same GP practice for a number of years.

3.3.5.2 Although there is no indication within the records reviewed to suggest that domestic abuse was an issue in Judith and Frank's relationship, in 2012 Judith attended the GP for an appointment and during the course of the examination, a soft tissue bruise was noted. When asked by the GP, Judith said that she did not know how this had occurred. The onward referral letter stated that she was unsure how this had occurred though reported that she had a disabled child.

3.3.5.3 Throughout the IMR provided on behalf of the GP, there is evidence of a number of occasions when members of the family did not attend appointments. It was noted that there were a number of times when recalls were placed on the system as when the parents were informed of the need to bring their child to the surgery for a health intervention, appointments were not made in a timely fashion with several requests for attendance having to be sent at times.

3.3.5.4 It was known within the GP practice that Frank and Judith were caring for their disabled child and a 30-year-old foster son with severe learning disabilities. When Judith took her child for a general review it was highlighted by the GP that their child was due to leave school. Judith reported to the GP that she was happy to have her living at home although she did identify that the long-term plan was for her to reside in a group home.

3.3.5.5 There were four episodes when Frank did not engage with the yearly diabetes screening programmes available. These were in 2008 and between 2012 and 2015. It is also noted in the IMR that there were several occasions when Frank made the decision to discontinue his diabetic medication and on one occasion this lasted for up to two years. Whilst undertaking this review, it has been clear that the GP practice did not have a robust procedure in place for monitoring uncollected prescriptions of medications prescribed by the GP and therefore the associated impact on the health and wellbeing of the patient was not assessed. It is noted that Frank (and his family) all disagree with the inference that he was not managing his diabetes. He was, in their words, a very fit man who was managing his diabetes through diet and exercise. They do, however, acknowledge that in the lead up to the homicide he was not doing this as effectively as he had in the past but that this was a short-term issue.

3.3.5.6 The GP practice highlighted, as part of this review, that there is an existing process for undertaking searches for patients who are not compliant with anti-psychotic medication however, following this review this process will be widened to cover more medications. The GP practice confirmed that they complete a monthly check through the paper FP10s for non-collected prescriptions and intend, going forward, to look in more depth at the reasons for non-collection or repeat trends. The GP practice also identified that further investigation

regarding compliance with medications ordered via electronic prescribing (and subsequent non-collection from the pharmacy) was required in order to be assured that patients were receiving their required treatment.

Recommendation One

GP practices should ensure that there are robust processes in place for monitoring the collection of prescribed medication and consider the impact of non-concordance of those with caring responsibilities

3.3.5.7 It does appear that Frank was referred on to relevant health services according to his health needs.

3.3.5.8 In August 2016, Frank attended the GP due to stress and trouble sleeping. The GP records state that when asked, Frank stated that he was not experiencing any thought of Deliberate Self Harm (DSH). Frank has told this review that he said he was suicidal at the time. It is noted by the GP that Frank said that his 'tax affairs' were causing him worry. He was, on this occasion, prescribed some short-term medication to be taken as required and it was recorded that he should return to see the GP if he needed a further prescription. He was reviewed by the GP in September 2016 but there is no indication that his previous concerns about stress were discussed by the GP or raised by Frank as an ongoing concern.

This was potentially a missed opportunity to pursue with Frank his ongoing mood and review whether he was still struggling with stress and lack of sleep

3.3.5.9 At the beginning of August 2017, one year on from his previous reports of stress, Frank visited the GP and stated that he was experiencing increasing anxiety, night time waking and 'a bit of low mood' and again it is documented that he said he was not experiencing any thoughts of Deliberate Self Harm. Frank has told this review that this was the worst he had ever felt in his life. When the GP saw Frank a week later for his diabetic review, he said that he had not been taking the medication for a long time due to anxiety. He was advised by the GP to recommence his medication. This was the last time he attended the surgery before the homicide.

It is noted that there does not appear to have been any recorded discussion about the reason for the increased stress and anxiety. We are unable to say whether the impact of his caring responsibilities was discussed. The review recognises the pressures placed upon GPs but a more descriptive note would help other healthcare professionals understand the issues. This was potentially a missed opportunity.

Recommendation Two

When identified carers disclose mental health conditions such as stress, anxiety and low mood conversations should occur with the patient as to whether additional support is needed. Whilst this has arisen from this particular review, we feel that this recommendation and its context should be brought to the attention of all organisations supporting carers across the County and thus this Review should be sighted by the County's Adult Safeguarding Board.

3.3.5.10 The GP practice reported that they have a carers' register in place in the practice but that it relies upon self-identification and that it can be time consuming to keep it up to date. It was confirmed that patients are offered a carer's assessment and provided with information about further support if they need it. It was noted that the Systmone contains an Ardens template which acts as an aide-memoir for staff undertaking assessments. The GP practice made changes to practice in response to their review:

- They intended to use the upcoming flu campaign to raise awareness regarding carer roles and increase recognition
- A question was added to the new patient registration form which asks, 'do you look after someone?'. The response to this question will promote the offer of assessment and support

3.3.5.11 It was noted as part of the IMR, that on Frank and Judith's child's notes there was a record noting 'Did Not Attend' (DNA) but that it would be good practice for the term 'Was Not Brought' to be used where a patient is not able to bring themselves to appointments as they are dependent upon carers. It was also noted that a robust process is needed to follow up any non-attendance.

3.3.5.12 After discussion with the GP practice it has been highlighted that the system used (Systmone) allows a code for DNA to be added. However, there is no code for WNB on the system. The practice has therefore agreed to proactively follow up vulnerable patients who are not in attendance for arranged appointments. The DNA code will be applied to the record and the clinician for whom the appointment was arranged will follow this up with a phone call and where necessary, a letter.

3.3.5.13 The review is aware that there has been significant work undertaken locally to highlight the issue of recording WNB as oppose to DNA. This has been strengthened both with an animation for professionals and a more recent animation for the public around the importance of ensuring that children and dependent adults are brought to appointments.

Recommendation Three - National

It is recommended that the suppliers of the Systmone system make the necessary upgrade to provide a WNB code and this is communicated to all users of the system, along with the reasons for using this new code.

This is a national recommendation for NHS Digital (via the Department of Health) as the Panel feel that all users of Systmone would benefit from this additional code.

Recommendation Four

It is recommended that where patients do not have the capacity to bring themselves to appointments as they are dependent upon carers, agencies should ensure that there is a robust process for following up non-attendance for required health checks.

Recommendation Five

It is recommended that the CCG should work with primary care services to develop a carers' charter which practices could use to support implementation of best practice for offering support to individuals who identify themselves as carers

Whilst arising from this particular review and its context we feel that Recommendations Four and Five should be brought to the attention of all organisations supporting carers across the county and thus this review should be sighted by the County's Adult Safeguarding Board.

3.3.6 Nottinghamshire Healthcare NHS Foundation Trust

3.3.6.1 Frank was engaged with Podiatry Services for a short period in 2016 when he was seen for management and treatment of diabetic foot care. This involved advice and treatment. Frank was considered low risk and was discharged in May 2016. There is nothing of concern in these records.

3.3.6.2 Frank and Judith's child was involved with services until she was transferred from the Child Paediatric Services to the Adult IDD team. There is nothing in the files to suggest that there were ever any safeguarding concerns.

The review notes that over the past 18 months significant work has taken place across the trust to embed the Think Family approach. The trust is now focussing on domestic violence and abuse with all staff for an additional period, thereby ensuring that Routine Enquiry is embedded, and partners receive a holistic Think Family service. There are no specific recommendations for the Trust.

3.3.7 Nottinghamshire Police

3.3.7.1 Neither Judith nor Frank had any criminal convictions. There are no recorded incidents of domestic abuse held by the police.

The review is satisfied that if any domestic abuse existed within the relationship it was unreported and therefore there are no areas of specific learning for the police.

Section Four – Other issues considered

4.1 The impact and responsibility of the couple acting as carers

4.1.1 The part that their child played in the family is significant to the time leading up to Judith's death and, for this reason, will feature within this review. She was described as a young person with profound and multiple learning difficulties. As a result of this the local authority maintained a statement of educational needs for her from 2002. At this time, the statement describes her as having Down syndrome, West syndrome (recurrent epileptic fits), very limited communication and limited independent mobility. There are also concerns about her hearing and vision. Although the child's mobility developed considerably whilst growing up, intellectual abilities and communication skills made only slow progress. At some point at the beginning of 2017 (which is not clear) the child received an additional diagnosis of Autistic Spectrum Disorder.

4.1.2 In order to assist the review in understanding these difficulties, their child has been described as having the mental age of a 10-month-old child. The child has a generally happy disposition and positively enjoyed sensory stimulation through music, dancing, eating and touch. The child is non-verbal and unable to use Makaton to communicate. However, the child is able to express a preference for an item or activity by taking a trusted adult's hand and leading them. Due to Down's Syndrome the child had a level of unsteadiness when walking.

4.1.3 One issue of their child's care caused what has been described by several people, including Frank, as an ongoing tension between them. In fact, the evidence would seem to suggest that this issue was at the core of any other disagreements they would have had. Judith had very strong views about the use of medication in relation to sedating children with disabilities. Judith's brother said this developed in her teens when she volunteered helping children with disabilities and witnessed what she described as a 'medical cosh' given to those children to help them sleep. It seems that Judith felt this was often given more for the benefit of the carers than the child; she was vehemently opposed to its use. The child had trouble sleeping and this in turn meant that sleep was almost always disturbed for Judith and Frank. Whilst it appears that Judith was able to cope with this, Frank struggled. He struggled to the point that at times he would go to a nearby house that they owned, to sleep there. Medication had been prescribed to help their child sleep, but Frank said that Judith often failed to give it or would only give part of the dose and he says that he found medication hidden in the bin. This issue caused an ongoing tension and there is no evidence that they sought advice about it, rather they tried to deal with the issue themselves.

4.1.4 Frank and Judith's child attended an SEN school from 2003 until July 2017.

4.1.5 The staff at the home providing respite care for their child had not met Frank but described Judith, who was the main point of liaison, as a devoted parent. It was said that, 'her child was her world' and she positively embraced her child's disability and celebrated the small steps of progress. They were also aware that the family undertook a lot of activities together. It was noted by the home, that the family would often miss the scheduled stays in the home and when contact was made, Judith would say that they had forgotten or were away.

4.1.6 One officer interviewed for this review, had met both Judith and Frank on three different occasions for formal review meetings of the care being provided to her. She said that both

parents appeared very engaged with their child's care and development and there was nothing that struck her as unusual or of concern. She did comment that on one occasion she happened to bump into Judith and her child on a trip out. When she made a comment, along the lines of, 'is this a family outing?' Judith replied in a dismissive tone words to the effect of 'oh no – it's just my child and me as usual'. At the time, this struck the officer as odd and at variance with what she had observed in formal meetings, but she was not overly concerned.

4.1.7 When she was assessed in March 2016 it was noted that both parents contributed to the assessment. It was noted that, although she could not communicate verbally, she appeared happy when she saw her mum and dad. At this time, it was noted that Judith was her appointee and helped with personal care for her. It was noted, as part of the assessment, that she did regular activities with her parents.

4.1.8 The review has heard from family and friends that the transition from children's services to adult services was a stressful time for the family. During interview, after his arrest, Frank told police that the pressures had increased after the child turned 18 years old. He told them that all the respite care ceased overnight and that this was now 'biting'. He told police that the respite care was extremely important, and that Judith coped with the situation very well, but he could not find a way out.

4.1.9 The review found that whilst there has been a lot of emphasis placed on the role of the respite care, Frank and Judith did not take advantage of all the support that was available to them. Minster View reported that they had only accessed 25 overnight stays between 2009 and 2016 for the child. Staff recalled that they often forgot to bring her for her overnight stays as they were often on holiday.

4.1.10 In the time leading up to the child's transition to adult services, staff had made arrangements for Frank, Judith and their child to visit provision for overnight respite. Although visits were made, the couple were very reluctant for the child to go despite attempts by social workers to facilitate this.

4.1.11 When asked about this Frank was clear that this was a decision that both he and Judith took together. They had both had experiences of adult care homes in the past – Judith from her previous employment and Frank from supporting former foster children who were in homes. Both were reluctant to leave their child overnight in a place that they were not happy was suitable for her particularly because of her ability to communicate which they felt left her more vulnerable. Family and friends have confirmed that Judith and Frank would often be out or away as a family. A number of family members had offered to look after her, but this had mostly been declined. In their view, respite care was not something that was verbalised as an issue to them by Frank and Judith.

4.1.12 The review acknowledges that research suggests that couples caring for a disabled child are at greater risk of relationship issues leading to separation[7]. One important factor is how different coping styles affect parents' ability to draw strength from one another and handle the pressures and circumstances of caring responsibilities. The research showed that supportive couples protect one another from the stresses and risk of depression associated with caring for a disabled child.

[7] Growing together or drifting apart, www.oneplusone.org.uk cited in Relationships and caring for a disabled child, contact a family for disabled children

4.1.13 The review has been struck by the care and dedication that both Judith and Frank gave to their child throughout her life, always looking to expand her horizons and give the child as many positive experiences as possible. Many people have talked to the review about them taking her out and away on holiday.

4.2 Frank's mental health

4.2.1 We know that in August 2016 Frank attended his GP who records this as being due to stress and trouble sleeping. According to his GP, Frank confirmed that he did not have any thoughts of Deliberate Self Harm and was prescribed with short term medication to be taken as needed. He did not return to the GP for a further prescription and it is not known if he used this prescription. Frank's recollection of this visit is that he told the GP that he was feeling suicidal.

4.2.2 Frank attended his GP on 1st August 2017 and his GP's record states that he was experiencing increasing anxiety, night time waking and was 'a bit low in mood' and again he said he had no thoughts of Deliberate Self Harm. Frank recalls that he told the doctor that he felt like he was 'going through glue' and felt worse than he had ever done before. He thought that the GP would infer from that statement that he was feeling suicidal again. Frank is clear, when he recollects this consultation that he had a responsibility to tell the GP that he was feeling suicidal.

4.2.3 Frank was seen by the same GP a week later when he said he had not been taking his diabetic medication for a long time due to anxiety. He was advised to recommence his medication. This consultation was two weeks before the homicide.

4.2.4 Frank talked at great length about his state of mind in the weeks leading up to the homicide and describes that he stopped taking his diabetes medication because he did not care, and he just wanted to die. He said that his brain was telling him that life was not worth living.

4.2.5 Those who have spoken to the review have all talked about a change in Frank in the recent years leading up to the homicide that was out of character for him. He became snappy and argumentative and would become fixated on a topic, becoming worked up about things that were not important. On one occasion, he had called a close friend as he was very concerned about some financial matter and, in the view of the friend, he was disproportionately worried about this.

4.2.6 Over the years Judith and Frank had been on holiday with their close friends about thirty times. Three weeks before the homicide, they were away in a cottage with this family and another couple who were mutual friends. They said that there were no signs that Frank and Judith did not love each other any more in fact the opposite was the case. However, Frank was not his normal self. He was more withdrawn and not as sociable as usual. He was becoming anxious about simple things. For example, he would worry unnecessarily that there was not enough food and insist on going shopping. This change was so noticeable that the friends spoke to Judith about this. Judith was very worried about Frank and was trying to get him to see his GP and she was not sure if he was taking his medication. Judith was so concerned that she asked her friend to engineer a conversation to talk to Frank, but the opportunity did not arise during the holiday.

4.2.7 At the end of the holiday, one of the friends drove Frank and Judith home and stayed overnight with them. The next morning, they had a long conversation together about how

Frank was feeling. Frank admitted that he was not great and was worried and anxious about all sorts of things.

4.2.8 On the weekend before the homicide, Frank spent time with one of his brothers. They had gone out to collect a piano and Frank was very quiet and seemed distant. He did not 'seem right' and his brother had made an excuse to drive the car. When they went out for a meal that evening, Frank was very quiet and so his brother's wife rang to speak to Frank to see how he was.

4.2.9 On the day of the homicide, his brother's former foster daughter spoke to Judith on the phone. She had said that Frank was 'not his usual self' and was withdrawn and staying in his bedroom when usually he would be out and about. She said that Frank had been to the GP but was not sure if he had told him how he was feeling. She said, 'you know what he is like' and she was going to talk to him about going again to the GP.

4.2.10 The sentencing hearing was told that Frank was suffering from a depressive illness that severely impaired his reasoning at the time of the homicide. He suffered a temporary loss of self-control. Although Frank was depressed, he was not, however, psychotic. There was a level of pre-meditation in the act as the rolling pin and knife had been taken into the living room.

4.2.11 When the Independent Chair and Report Author met with Frank and members of his family, they all talked about an incident that happened some five or six years ago when he fell out of a tree. It was a severe fall, but he refused an ambulance and carried on working. The next day he woke with, what is described as, Bell's Palsy on one side of his face, he was cross-eyed and dribbling. He recollects that he went to see his GP who felt that the symptoms were caused by his diabetes not being under control and, in his words, he ignored what he said about the fall. He was not referred for any further tests or treatment and over the next few months the symptoms waned. All of his family now feel that this was the point at which his personality began to change.

4.2.12 Having had the GP records rechecked, the review has been able to establish that Frank attended an Emergency Department in September 2011 with sudden onset of weakness to the right side of his face. He had no headache, blurred vision or wider limb weakness reported or noted. He reported that he felt well but had some residual right sided facial weakness. He was diagnosed with Bell's Palsy and appropriate intervention offered.

4.2.13 Whilst this is a matter that is worthy of note within the review, it should be noted that not all those spoken to place the same level of importance to this homicide and there is nothing in the medical records to suggest that it had a long-term impact upon him.

4.2.14 One of the issues that has been very clear as we have talked to Frank and his family is the reluctance on the part of Frank to talk about his mental health. Frank says that because of his generation and background he could not talk about his mental health. It has been very clear from recent coverage in the media that men can find it very difficult to talk about their mental health. This may be for a variety of reasons:

- That it is seen as a sign of weakness
- That a man should be able to control his feelings
- That men should not ask professionals for help
- That talking about it won't help

- That it will make you a burden to others

4.2.15 It is also very clear that Frank, as the 'head' of the family was the man who sorted out everyone else's problems, who people came to for help. This made it very difficult for him to talk about how he was feeling.

This Review identifies a stigma and reluctance still to talking about mental health, particularly amongst older people and men. We welcome the impetus around national campaigns looking at men's mental health

The review also notes that Judith had been very concerned about Frank prior to the homicide and had said that she felt that there was no point in her going to talk to the GP as he would not discuss it with her. Whilst the need for patient confidentiality is paramount, the Review feels that concerned relatives should be able to seek help and advice and believe that they will be supported.

Recommendation Six – National
As this is an issue likely to be of concern across boundaries, it is recommended that public health bodies are asked, through the Department of Health, to consider promotion around how people can access support if they are concerned about a family member. For example, posters about how women encourage men in their lives to access support if they are showing symptoms of prostate cancer.

4.3 National Confidential Inquiry into Suicide and Safety in Mental Health[8]

4.3.1 The NCISH database is a national case series of suicide, homicide and sudden unexpected death (SUD) by mental health patients over 20 years. The current suicide database stands at almost 127,000 suicides in the general population, including over 33,500 patients. This large and internationally unique database allows NCISH to examine the circumstances leading up to and surrounding these homicides and make recommendations for clinical practice and policy that will improve safety in mental health care.

4.3.2 **Patient homicide**

4.3.3 During 2006-2016, 11% of homicide convictions in the UK were perpetrated by mental health patients, a total of 785 patient homicides over the report period, an average of 71 homicides per year. 6% were perpetrated by people with schizophrenia, an average of 37 per year, including both patients and non-patients. In England, the number of homicides perpetrated by patients since 2009 has been lower than in previous years. Of all patient homicides, 86% have been committed by male patients, 81% of those were not currently married. The average age of those offenders is 33 years but ranges from the ages of 13-83. 30% of those offenders were living alone, 82% of them were unemployed or on long term sick leave. 20% of their victims were family members as opposed to only 18% of which were spouse/partner including ex and 47% were classed as an acquaintance.

4.3.4 Detailed analysis of patient homicide since 1997 has highlighted:

[8] https://sites.manchester.ac.uk/ncish/

- The victim is most likely to be an acquaintance and less likely to be unknown to the perpetrator than in homicides by non-patients
- Most patients had a history of alcohol or drug misuse
- Homicide in the absence of comorbid substance misuse is unusual, around half of patients were not receiving care as intended, either through loss of contact or non-adherence with drug treatment. Patients are also at high risk of being victims of homicide
- Most victims of patient homicide were an acquaintance (45%) or a family member including spouse (40%).

4.3.5 The most common primary diagnosis was schizophrenia and other delusional disorders (29%), followed by drug dependence/misuse (16%). Most patients (89%) convicted of homicide also had a co-existing problem of alcohol or drug misuse.

4.3.6 Almost half of all the offending patients (628, 48%) were non-compliant with treatment or had lost contact with services. In a recent study, homicide offenders diagnosed with schizophrenia were more likely to have been disengaged with services prior to the offence. Therefore, services can help by being aware of the risk of losing patient contact as well as the problems of substance misuse and the higher risk of patients being victims of homicide.

Section Five – Lessons Learned

5.1 There were no robust processes in place in the GP surgery for monitoring when prescribed medications were not collected.

5.2 The GP practice did not have a robust process for considering the impact of non-concordance with medication of those with caring responsibilities.

5.3 When Frank disclosed stress and anxiety to his GP there was no conversation to establish if, as a carer he and his wife, needed additional support.

5.4 The SystmOne used in the GP practice does not allow a 'Was Not Brought' code to be put against a patient's record.

5.5 Non-attendance of Judith and Frank's child at medical appointments was not followed up.

Section Six - Conclusions

6.1 At the conclusion of the criminal trial the judge, in his sentencing remarks, described the outcome as 'a tragedy'. He said that there was no real reason why it happened, it was unnecessary, it was avoidable, Frank knew he was feeling unwell and had a supportive network of family, friends and health professionals who he could have turned to.

6.2 This review has considered in depth whether domestic abuse was a feature of this relationship and, if so, when and why it developed and the role it played in Judith's death. We have articulated our considerations at section 3.2 within this report. Whilst there is some evidence to suggest there was, this largely comprises two excerpts of recorded material. Despite enormous efforts made by the police and again by this review, that material cannot be placed in context. Whilst the content may speak for itself, coupled with the awful events leading to the death of Judith, it is countered by the consistency in accounts of all those spoken to by police and this review who say without hesitation that it is not reflective of the relationship as they understood it to be. Tension clearly existed within the relationship resulting from a long-standing disagreement between them as to how best meet the needs of their child. This was coupled with Frank's deteriorating mental ill-health, which may or may not have been linked with that disagreement. Given all that we have learnt this review is unable to conclude whether prior domestic abuse was present or not. There was no evidence available to agencies to suggest that domestic abuse was a feature of their relationship.

6.3 The impact that Judith and Frank had on many young people's lives cannot be understated. They changed the lives of many people for the better.

6.4 Frank had a supportive family and it is truly a tragedy that he did not feel able to turn to them for help.

6.5 The review panel extends its sympathies to the family and friends.

Section Seven – Recommendations

7.1 GP practices should ensure that there are robust processes in place for monitoring the collection of prescribed medication and consider the impact of non-concordance of those with caring responsibilities

7.2 When identified carers disclose mental health conditions such as stress, anxiety and low mood conversations should occur with the patient as to whether additional support is needed. Whilst this has arisen from the particular review, we feel that this recommendation and its context should be brought to the attention of all organisations supporting carers across the County and thus this review should be sighted by the County's Adult Safeguarding Board.

7.3 The suppliers of the Systmone system make the necessary upgrade to provide a WNB code and this is communicated to all users of the system, along with the reasons for using this new code. This is a national recommendation for NHS Digital (via the Department of Health) as the Panel feel that all users of Systmone would benefit from this additional code.

7.4 Where patients do not have the capacity to bring themselves to appointments as they are dependent upon carers, GP practices should ensure that there is a robust process for following up non-attendance for required health checks.

7.5 The CCG should work with primary care services to develop a carers' charter which practices could use to support implementation of best practice for offering support to individuals who identify themselves as carers

7.6 (National) It is recommended that public health bodies are asked, through the Department of Health, to consider promotion around how people can access support if they are concerned about a family member. For example, posters about how women encourage men in their lives to access support if they are showing symptoms of prostate cancer.

Whilst Recommendations Four and Five have arisen from the particular review, we feel that these recommendations and their context should be brought to the attention of all organisations supporting carers across the County and thus this review should be sighted by the County's Adult Safeguarding Board.

Appendix One - Terms of reference

OPERATION HASLOCK
Terms of Reference for the Domestic Homicide Review into the death of Judith

1 Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by Bassetlaw, Newark and Sherwood Community Safety Partnership (BNSCSP) in response to the death of Judith which occurred in August 2017.

5.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

5.3 The Chair of the BNSCSP has appointed Mr Gary Goose MBE to undertake the role of Independent Chair and Overview Author for the purposes of this review. Mr Goose will be supported by Mrs Christine Graham. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

6 Purpose of the review

The purpose of the review is to:

2.1 Establish the facts that led to the homicide in August 2017 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

2.3 Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the homicide in August 2017; suggesting changes and/or identifying good practice where appropriate.

2.4 Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

2.5 Contribute to a better understanding of the nature of domestic violence and abuse; and

2.6 Highlight good practice.

3 The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with, any on-going criminal justice investigation and the process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this homicide in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

4 Scope of the Review

The review will:

4.1 Consider the period of two years prior to the events (unless there are significant incidents prior to this date), subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

4.2 Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.3 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

4.4 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

4.5 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5 Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6 Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then NBSCSP will be the first point of contact.

7 Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.