Domestic Homicide Review

Into the death of Helen

2021

Overview Report

Report Author: Dr Liza Thompson

Commissioned by: Norfolk Community Safety Partnership

Review completed: March 2023

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GLOSSARY

AP	Assistant Practitioner
ADASS/LGA	Association of Directors of Adult Social Services/ Local Government Association
AMHP	Approved Mental Health Practitioner
ASSD	Adult Social Services Department
DHR	Domestic Homicide Review
DASH/DARA	Domestic Abuse Stalking Harassment/Domestic Abuse Risk Assessment – both forms of risk assessment for domestic abuse
GDPR	General Data Protection Regulations
IMR	Individual Management Review
Las	LiquidLogic Adult Social Care Data System
LPA	Lasting Power of Attorney
MHA	Mental Health Act
NCC	Norfolk County Council
NSAB	Norfolk Safeguarding Adults Board
OT	Occupational Therapist
SCCE	Social Care Community Engagement
SCCE AP	Assistant Practitioner working in the Social Care Community Engagement team
SAPC	Safeguarding Adults Practice Consultant
Perpetrator	Social Worker
S42	Section 42 of the Care Act (relates to safeguarding adults)
SARs	Safeguarding Adult Reviews

1. Introduction

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Helen, a resident of Town A, prior to the discovery of her death in October 2021.

1.2 Norfolk County Community Safety Partnership, the Independent Chair, panel members and everyone involved in this review would like to extend their sincere condolences to Helen's family and friends. Helen is remembered with immense love and affection by her family. The NCCSP would like to thank them for their bravery, integrity and assistance participating throughout this review of the tragic circumstances of Helen's death.

1.3 Helen was a white British woman in her mid-fifties, who had been living with Huntington's Disease.[1]

1.4 On 21st October 2021, Helen's nephew contacted Police with a concern for her safety. Helen had not been seen in person since September 2018, with communications since then only being via text message.

1.5 Two of Helen's family members had knocked at Helen's home the day before, and her partner, Perpetrator had told them that Helen had left him eighteen months before and moved in with a friend. They felt this explanation was unlikely as due to Huntington's Disease, she would need a carer and the name of the friend that Perpetrator gave them was unknown to her family.

1.6 Norfolk Constabulary investigated Helen as a missing person, and on 30th October Perpetrator was arrested for murder.

1.7 Less than a week later Helen's body was located in a shallow grave on the property she had shared with Perpetrator (Westbrook Place)[2]. A post-mortem examination documented the presence of severe traumatic head injuries of a blunt force nature, which were consistent with Helen having been repeatedly struck with a heavy blunt object. Her body had been in situ for a number of years.

1.8 Perpetrator was found dead in his prison cell whilst on remand on 29th December 2021 with severe blood loss due to a self-inflicted wound to his neck.

1.9 This DHR examines the involvement that organisations had with Helen from 1st July 2015 to 31st October 2021.

1.10 Perpetrator was a white British male, who was in his mid-fifties when he took his own life. This DHR also examines the involvement that organisations had with Perpetrator from 1st July 2015 to 31st October 2021.

[1] A condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotions.

[2] Not the real name

1.11 Norfolk County Community Safety Partnership chair was notified of the Helen's death in October 2021, and in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a DHR Gold Panel meeting was held on 2nd December 2021, where it was agreed by the Chair and Partners, that the criteria for a DHR had been met and that the review would be conducted using the DHR methodology. That agreement was ratified by the Chair of the Norfolk CSP and the Home Office were informed on 6th December 2021.

1.12. Following the appointment of the Independent Chair in December 2021 and the outcome of the criminal justice proceedings, the review began on 18th March 2022, with the initial panel meeting, where the Terms of Reference were agreed.

2. Confidentiality

2.1. The findings of this DHR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DHR has been approved by the Home Office Quality Assurance Panel and published.

2.2. Details of the deceased and perpetrator:

Name	Gender	Age at time of death	Relationship to deceased	Ethnicity
Helen	Female	56	*Deceased*	White British
Perpetrator	Male	56	*Partner and perpetrator*	White British

3. Publication and Dissemination

3.1. This overview report will be published on the Norfolk County Community Safety Partnership published Domestic Homicide Reviews webpage.[3]

3.2. Family members will be provided with a printed copy of the report prior to publication on the webpages.

3.3. Further dissemination will include:

- Independent Chair and all members of Norfolk Community Safety Partnership
- Police and Crime Commissioner for Norfolk
- Chief Constable Norfolk Constabulary
- Chief Officer – Norfolk and Waveney Integrated Care Board
- Chief Officer – Norfolk and Suffolk Foundation Trust

[3] Published Domestic Homicide Reviews for Norfolk County (norfolk-pcc.gov.uk)

- Chief Executive - Cambridge University Hospitals NHS Foundation Trust Chief Executive – Norfolk and Norwich Hospital University Foundation Trust
- Executive Director – Adult Social Services, Norfolk County Council
- Office of the Domestic Abuse Commissioner

4. Methodology

4.1. Following notification of a domestic homicide, all the Norfolk County Community Safety Partnership (NCCSP) members were asked to conduct a search of agencies records for information held about Helen and/or Perpetrator.

4.2. Initial information was shared by Norfolk Constabulary, Adult Social Care, GPs for both parties, Department of Work and Pensions (DWP), Cambridge University Hospitals NHS Foundation Trust (CUH), Norfolk and Norwich Hospital Trust, East of England Ambulance Service and Norfolk Community Health and Care. All other agencies returned a nil response – indicating they had not engaged with Helen during the scoping period.

4.3. The detailed information on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Helen and/or Perpetrator. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

4.4. The majority of the IMRs were written by a member of staff from the organisation to which it relates. The GP Practice IMRs were written by the Norfolk Integrated Care Board. Each IMR signed off by a Senior Manager of that organisation before being submitted to the DHR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Helen or Perpetrator during the period covered by the review.

<u>Cambridge University Hospitals NHS Foundation Trust (CUH)</u>

4.3. The IMR writer reviewed Helen and Perpetrator's electronic medical records, this included clinic letters, consultants' written notes, appointments, email correspondence with the Neurology clinic and telephone contact with administrative clinic staff.

4.4. There was also a review of the hospital's Did Not Attend (DNA) policy which was in place during 2018/19.

<u>Primary Care</u>

4.5. For the purposes of the report, Practice A is the surgery where Helen was registered at the time of her death and Practice C is the surgery where Perpetrator was registered.

4.6. The available GP medical records were reviewed for both Helen and Perpetrator.

4.7. The IMR author attended a meeting with Practice A's Practice Manager, Practice Safeguarding Lead and the GP who had the most contact with Helen. The purpose of the meeting was to discuss the DHR and learning for the Practice.

4.8. The Practice Dispensary provided feedback and the IMR author also emailed the Practice Safeguarding Lead with follow up questions.

Adult Social Care

4.8. In completing the IMR for Adult Social Care, the author undertook review of the relevant records on the adult social care electronic case recording system Liquid Logic Adults System (LAS).

4.9. There was an interview carried out on with the Safeguarding Adults Practice Consultant (SAPC), and an interview with the Social Care Community Engagement Team Assistant Practitioner (SCCE AP).

4.10. The author also consulted with the SCCE service manager about expectations regarding carers assessments, and with the training lead for adult safeguarding.

5. Terms of Reference

5.1. The review Panel first met on 18th March 2022 to consider draft Terms of Reference, the scope of the DHR and those organisations whose involvement would be examined. The Terms of Reference were agreed subsequently by correspondence and form Appendix A of this report.

5.2. The Purpose of a DHR

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse.
f) highlight good practice.

5.3. The Focus of this DHR

5.3.1. This review will establish whether any agencies had identified possible and/or actual domestic abuse – in all its different forms - that may have been relevant to the death of Helen.

5.3.2. If domestic abuse was not identified, the review will consider why not, and how such abuse can be identified in future cases.

5.3.3. If domestic abuse was identified, the review will examine the method used to identify risk and the action plans put in place to reduce that risk.

5.3.4. This review will also consider current legislation and good practice.

5.4. Specific Issues to be Addressed.

- Were practitioners sensitive to the needs of Helen and Perpetrator. Were they knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
- What mechanisms were in place to follow up with Helen, following her total disengagement with health services after October 2018?
- How did the Covid-19 pandemic restrictions effect mechanisms to follow up with Helen when she seemingly disengaged with services.
- Identification, understanding and responses to any economic abuse perpetrated by Perpetrator.
- Was Helen identified as a vulnerable person due to living with Huntington's Disease?
- What were the agency responses to concerns raised by Helen's family in August 2018?
- When, and in what way, were Helen's wishes and feelings ascertained and considered?
- How accessible were the services to Helen?
- Did the agencies comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

- Were senior managers or other agencies and professionals involved at the appropriate points?

- Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Helen, and promote their welfare, or the way it identified, assessed and managed the risks posed by Perpetrator?

- Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

6. Involvement of Family Members and Friends

6.1. Norfolk County Community Safety Partnership (NCCSP), the Independent Chair, panel members and everyone involved in Helen's review extend their deepest condolences to her family and friends and thank them for their bravery and integrity throughout this review process.

6.2. Following the decision in December 2021 to conduct a DHR, the Police Family Liaison Officer assisted with notifying Helen's family of the DHR, a formal DHR notification letter was posted to the family, and in January 2022, the Chair of NCCSP informed the family of the appointment of the Independent Chair.

6.3. On 10th January 2022, the family's Victim Support Caseworker contacted the DHR Coordinator, indicating that the family would like to engage in the DHR process. On the same day, the Independent Chair contacted the Caseworker and obtained Helen's brother's email address.

6.4. On 11th January 2022, the Chair emailed Helen's brother, who provided the contact details for Helen's sister, niece, nephew, and close friend. Email exchanges took place and between 14th and 27th January 2022, the Chair spoke to each family member individually, either by phone or in a virtual meeting depending on their preference.

6.5. During these meetings, the Chair introduced herself, explained the DHR process and explained how the family would be vital to the DHR in order that Helen's voice be heard throughout. It was then agreed that the Chair would visit the family for the day to interview them individually about Helen.

6.6. On 10th February 2022, the Chair travelled to Helen's niece's house, located in Town B in Norfolk and interviewed the family members individually and also as a group.

6.7. The Chair spoke to Helen's brother and his wife. Helen had lived with Helen's Brother when he had first started dating his wife, and they both had stories to tell about a young Helen. In recent years they had moved out of county and so did not see as much of Helen as the others did. Helen's Brother did not carry the Huntington's gene but had lost family members to the condition and was able to provide a lot of information about Huntington's to support the writing of the review.

6.8. The Chair also spoke to Helen's sister and her husband. Helen's Sister is eighteen years older than Helen, and her memories were of Helen growing up. Helen's Sister and her husband helped Helen after she separated from the Perpetrator. They both commented on how Helen was a different person during this time she was separated from him, she would be more involved with the family and seemed happier. When they were back together, she became more remote from the family again.

6.9. Helen's nephew told the Chair how people found it strange when he introduced Helen as his aunt, because they were the same age. Helen's nephew's partner was able to give an insight into Helen during her nursing days as she had also worked for the same service. Both had met the Perpetrator on occasions due to work, and Helen's nephew had played cricket in the work's team with the Perpetrator. Helen's nephew's partner described her partner's relationship with Helen as being very close and they both described enjoying Helen's company at Christmas and summer get togethers.

6.10. The Chair also spoke with Helen's niece, who was also around the same age as Helen. Helen's niece described Christmas times when Helen stayed at their house, and they all sat up waiting for Santa. Helen's nephew and Helen's niece both told the Chair that they were more like siblings with Helen, than nephew and niece.

6.11. Helen's great niece told the Chair about the period when Helen was separated from the Perpetrator and was living with Helen's niece and her family. Helen's great niece described how fun her aunt was, and how much she enjoyed shopping.

6.12. Helen's friend also met with the Chair and talked about their longstanding friendship. She said she met Helen every few months for coffee, or lunch, and Helen confided in her about the Perpetrator's behaviours. Helen's friend was the last of the family and friends to have seen Helen. The last meet-up they had booked for 5th December 2018 had been cancelled via a text coming from Helen's phone – although she cannot be sure that this message was from Helen.

6.13. The family members gave such a rich account of Helen, they provided photographs and stories which illustrate how loved she was by them, and them

by her. They all described how they lost touch with Helen after she moved back with the Perpetrator, how when Helen could no longer drive herself, he did not take her to spend time with them. Most of them also described how the Perpetrator made it awkward for them- and for Helen if they visited her, by not speaking to them and standing around as if he was waiting for them to leave.

6.14. The Independent Chair also spoke briefly with Helen's friend Jill, who had been her named contact on health and social care records prior to Helen moving in with the Perpetrator.

6.15. The interviews with Helen's family were informal and semi-structured, asking questions about Helen, her relationship with the Perpetrator, Huntington's Disease, and anything else each person felt pertinent to the review. All interviews included the opportunity to ask questions for the IMRs and panel to consider, and this information informed the development of the Terms of Reference, which was agreed by the DHR Panel on 18th March 2022.

6.16. During the interviews, it became apparent to the Chair that the families' voices would add real value to the IMR writers' briefing[4]. Therefore, when the family were gathered, she asked if they would be willing to record short interviews about Helen, which the Chair would then edit and share with panel members, and IMR authors. The family unanimously agreed to this.

6.17. The interviews were recorded virtually between 10th and 21st March 2022. The family had sight of, and agreed, the final edited version, and this was shared with panel members and IMR authors on 31st March and 1st April 2022. Two dates were offered for this meeting to ensure as many professionals as possible could watch the video and learn about Helen ahead of embarking on the work of the DHR.

6.18. The panel considered that the level in which the family were involved with the review was exemplary. They recognise the value which is added when a family are integral to a review such as this. The Chair facilitated the processes in involving the family, and the panel will be making a recommendation that these processes are shared as good practice.

6.19. The family members were all supported by one Victim Support Homicide Caseworker, who was involved with them prior to the DHR Process commencing. Once the Independent Chair was involved with the review, she referred the close family friend to Advocacy After Fatal Domestic Abuse (AAFDA).

[4] This is a session which the Chair holds with IMR authors from across the agencies ahead of the IMRs being written. The Terms of Reference are discussed, and the Chair raises the profile of the victim by discussing their personal characteristics, sharing their family member's recollections of them, and sharing photographs of the victim. This focuses the authors' minds on the person they are writing about.

6.20. The family had sight of the report, and with the support of their advocate they met with the Chair to go through the details of the report. The family then provided their feedback and follow up questions for the DHR panel to consider.

6.21. The family met with the DHR panel on 18th April 2023 with support from their advocate. The session was an opportunity for the family to ask panel members questions, and further explore the recommendations and actions coming from Helen's review.

6.22. During the discussion, the family asked for reassurance that ASC are better at responding to people who may be financially abuse, or otherwise vulnerable due to domestic abuse. They were assured that ASC now work closely with domestic abuse services and are trained in professional curiosity. ASC cases are audited randomly to ensure processes have been followed.

6.23. The meeting was very positively received by all family members, who told the Chair that it allowed them to properly understand the report, but also enabled them to appreciate the way agencies and professionals interact and work together. The final report includes the family feedback.

7. Contributing Organisations

7.1 Each IMR was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation, before being submitted to the DHR Panel. None of the IMR authors or the senior managers had any involvement with Helen during the period covered by the review.

7.2 Each of the following organisations contributed to the review.

Agency/ Contributor	Nature of Contribution
Cambridge University Hospitals NHS Foundation Trust	IMR – in reference to the Huntington's Clinic which Helen attended
Norfolk and Waveney Integrated Care Board[5]	IMR– in reference to Helen and Perpetrator's GP Practices
Adult Social Care	IMR
Norfolk Constabulary	Summary report and detailed financial statement pertaining to Helen's and Perpetrator's bank accounts
Department for Work and Pensions	Summary report– utilising the IMR template
Huntington's Disease Association (HDA)	Provided advice to the Chair

[5]From July 2022 the Norfolk and Waveney Clinical Commissioning Group is known as NHS Norfolk and Waveney Integrated Care Board – this is due to the newly formed Norfolk and Waveney Integrated Care System obtaining legal status following the Health and Care Act 2022.

8. Review Panel Members

8.1. The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Helen and/or Perpetrator.

8.2. The members of the panel were:

Agency	Name	Job Title
	Dr Liza Thompson	Independent Chair
OPCCN	Amanda Murr	Head of Community Safety
OPCCN	Nicola Jepson	Community Safety Officer
Department of Work and Pensions	Lisa Barraclough	Advanced Customer Service Manager
Cambridge University Hospitals NHS Foundation Trust	Tracy Brown	Adult Safeguarding Lead
NIDAS	Kristal Oakley	Lead IDVA for NIDAS
Adult Social Care	Helen Thacker	Head of Service – safeguarding
Norfolk and Waveney Integrated Care Board	Gary Woodward	Adult Safeguarding Lead Nurse
Norfolk and Waveney Integrated Care Board	Dr Maria Karretti	Named GP for Safeguarding Adults
Norfolk and Waveney Integrated Care Board	Sara Shorten	Safeguarding Adult Nurse
Norfolk Safeguarding Adults Board	Walter Lloyd-Smith	NSAB Manager
Norfolk Constabulary (early part of the review – to share information only)	Matthew Connick	Detective Inspector (SIO)

8.3. The panel met on six occasions during the DHR – including a meeting with Helen's family.

8.4. All members of the panel were independent and had not been involved with Helen prior to her death.

8.5. Apart from the Norfolk Constabulary SIO, none of the panel members had been involved with the Perpetrator prior to his death.

8.6. The SIO had been involved with Perpetrator during the criminal investigation and attended an initial panel meeting, in order to share information about the investigation, and specifically regarding financial abuse element. Following this involvement, the panel did not include a representative from Norfolk Constabulary, as police had not been involved with Helen or the Perpetrator prior to Helen being reported missing. There was therefore no police involvement to analyse.

9. Independent Chair and Author

9.1. The Independent Chair, who is also the Author of this Overview Report, is Dr Liza Thompson.

9.2. Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHRs, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs) which has also assisted with this review. She delivers domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system, and she currently convenes a domestic abuse and sexual violence module at Canterbury Christchurch University.

9.3. Dr Thompson has no connection with the Community Safety Partnership and agencies involved in this review, other than currently being commissioned to undertake Domestic Homicide Reviews.

10. Other Reviews/Investigations

10.1. On 8th February 2022 the Crown Prosecution Service formally discontinued the criminal case against the Perpetrator following his death.

10.2. The coroner's inquest into Helen's death has been set for 9th May 2023 – the panel agreed to make the DHR report available for the coroner ahead of publication in order to assist with the inquest. This was at the family's request.

10.3. The coroner's inquest into the death of the Perpetrator took place over seven days in December 2022. A jury reached the verdict of suicide.

10.4. The Norfolk Safeguarding Adult Board Manager was involved with the panel and confirmed that a Safeguarding Adult Review was not undertaken as the criteria had not been met.

11. Equality and Diversity

11.1. The panel considered the nine protected characteristics under the Equality Act 2010, and discounted pregnancy and maternity, gender reassignment, race, religion and belief and sexual orientation.

11.2. However, the panel consider that Helen's life experiences, including her access to and experiences of health, care, and support services, were shaped by the

protected characteristics of disability - namely Huntington's Disease, sex, and marriage and civil partnership.

11.3. Huntington's disease is a genetic degenerative illness, which is caused by a faulty gene in chromosome 4. There is a fifty percent chance of passing the faulty gene on to children, and in Helen's case her father, uncle and aunt all passed away due to Huntington's.

11.4. Helen's family provided the Chair with information about Huntington's and how this had affected Helen. The Chair also met with, and was in contact with, a representative from the Huntington's Disease Association[6] throughout the review, in order to fact check information gathered and seek further information. The panel would like to thank the HDA for their time in supporting this review.

11.5. There are not currently any NICE guidelines for Huntington's but the Huntington's Disease Association website notes that the House of Lords has recently confirmed that the Department of Health and Social Care is preparing a paper on potential NICE guidelines for Huntington's.[7]

11.6. The faulty gene produces a protein called "Huntingtin"[8] which causes damage to nerve cells in the basal ganglia and the cerebral cortex, which leads to gradual physical, mental, and emotional changes.[9]

11.5. As the illness progresses, patients experience symptoms such as involuntary movements, difficulty in speech and swallowing, weight loss and emotional changes which can result in stubbornness, frustration, mood swings and depression.

11.6. Changes in cognitive function results in a loss of drive, initiative, and organisational skills. Sometimes, the resulting psychological problems can cause more difficulties for the patient– and their carer(s) than the physical deterioration.

11.7. Patients can appear intoxicated, due to the irregular movements and slurred speech.

11.8. People living with Huntington's are often diagnosed with depression, due to living with the symptoms of Huntington's but also because of the effects of the faulty gene upon parts of their brain.[10]

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[6] Huntington's Disease Association - Home (hda.org.uk)
[7] Huntington's Disease Association - United for change in Parliament (hda.org.uk)
[8] Genetics | Huntington's Victoria (huntingtonsvic.org.au)
[9] Duff, K., Paulsen, J. S., Beglinger, L. J., Langbehn, D. R., & Stout, J. C. (2007). Psychiatric symptoms in Huntington's disease before diagnosis: the predict-HD study. *Biological Psychiatry*, *62*(12), 1341–1346.
[10] Slaughter, J et al "Depression and Huntington's Disease: Prevalence, Clinical Manifestations, Etiology and Treatment" *CNS Spectrums* (2014)

11.9. There is no cure for Huntington's but there are ways to manage symptoms effectively.[11] Patients can be prescribed medication for involuntary movements, depression, and mood swings. Speech therapy can improve speech and swallowing. A high calorie diet can prevent weight loss but can also improve involuntary movement and issues related to emotional and cognitive changes.

11.10. Patients with Huntington's Disease are periodically assessed on an "independence score" which is calculated by their specialist and considers how acute their symptoms are, and their ability to complete a number of everyday tasks such as shopping, cooking, bathing and walking outside. The last time Helen was seen by the neurologist she was assessed at 60% on the independence scale – meaning that she required minor assistance in bathing, toileting, and dressing, and that food should be cut up for her – due to issues with swallowing.

11.11. A person living with Huntington's Disease will therefore become dependent on a carer over time. They will no longer be able to care for themselves physically due to unsteadiness and falls, and due to reduced cognitive function, they will be reliant on a carer to manage their financial and day-to-day decision making.

11.12. Risk factors linked to Huntington's can also include higher rates of criminality. Studies have found that there is a higher ratio of females with Huntington's Disease in the prison population, compared with the general population. This could be linked to frontal lobe deficits including disturbances of apathy, and executive disfunction including disinhibition, disorganisation, and poor judgement.[12]

11.13. Huntington's Disease patients are also at a significantly higher risk of suicidal behaviour.[13] This is associated with their cognitive function and behavioural issues. Impulsivity is commonly thought to be a risk factor, along with perseveration - repetitive behaviours - which leaves patients lacking the ability to transition or switch ideas within a social context.[14]

11.14. A person living with Huntington's Disease is therefore particularly vulnerable and in turn reliant upon the care of others.

[11] Roos, R. A. C. (2010). Huntington's disease: A clinical review. *Orphanet Journal of Rare Diseases*, *5* (1), 40–48.
[12] May-Yin, C et al "Huntington's Disease: A Forensic Risk Factor in Women" *Journal of Clinical Movement Disorders* 6 (2019)
[13] Kachian, Z et al "Suicide Ideation ad Behaviour in Huntington's Disease: A Systemic Review and Recommendations" *J Affect Disorder* (2019)
[14] Roman, O et al "Perseveration and Suicide in Huntington's Disease" *Journal of Huntington's Disease* 2 (7) (2018)

11.15. Caring for a person with Huntington's Disease can have a major impact on the health, wellbeing, and quality of life of the carer – this is particularly acute when the care is informal and provided by an individual within the home.[15]

11.16. Helen was a woman, living with Huntington's Disease, which forced her to be reliant upon others for her daily care and functioning. From 2016, Helen's care was provided by the Perpetrator, a male with whom she was currently – or had previously been - in a long-term intimate relationship.

11.17. Although Helen and the Perpetrator were not married, they had previously lived together in a relationship for many years and were recognised by services and professionals as a couple. It was recorded in hospital and GP notes that Helen had attended appointments with her husband or partner. Despite the Perpetrator telling police that during the period before Helen was killed, their relationship was not intimate, there was an assumption that he and Helen were a couple and therefore family.

11.18. The family unit is shrouded in privacy, Martha Fineman argues that:

> "society has devised special laws to apply to the family…these rules (are) justified by…the family's relational aspects and intimate nature."[16]

11.19. The privacy of the family setting has long been viewed as the primary source of women's oppression.[17] As Catharine Mackinnon argues "(the) ideology of privacy [is] a right of men to be left alone to oppress women one at a time."[18] The setting of the family home is private and therefore potentially untouchable by others; for example, Martha Fineman characterises the family as being "invisible" to those outside of it.[19] This privacy restricts state intrusion, "barring changes in control over….the existing distribution of power and resources within the private sphere."[20]

11.20. As described in the section above, Helen was also a woman living with a degenerative illness, which forced her to be dependent upon others, and led her to be isolated within the home due to lack of mobility, most notably when she was no longer able to drive.

11.21. Helen's family told the Chair how she was reliant upon the Perpetrator to take her anywhere, including to family events. He would not stay with her, but would wait outside, or come back to pick her up – which made socialising more awkward for Helen. Over time, Helen's contact with her family reduced, so much

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[15] Martins, R et al "Taking Care of People Suffering from Huntington's Disease: The Impact of Informal Caregivers Quality of Life" *International Journal of Arts and Sciences* (2018)

[16] Fineman, MA "What Place for Family Privacy" *Geo. Wash. L. Rev* (67) (1998-1999) p.1207

[17] Fineman, M *The Autonomy Myth* (2004) p.152

[18] Mackinnon, C "Roe v. Wade: A Study in Male Ideology" in Garfield, J L and Hennessey, P *Abortion: Moral and Legal Perspective* 45 (1984) p.53

[19] Fineman, above n 6 p.154

[20] Mackinnon, C *Toward a Feminist Theory of the State* (1989) p.193

so, that when she was not seen for many months, it did not seem unusual to them.

11.22. Helen was invisible from society due to her lack of mobility and the rural nature of Westbrook Place where they were living. This was further exacerbated by her dependency on the Perpetrator. This invisibility from society enabled the Perpetrator's coercive control to go completely unchecked, the assumption being that the Perpetrator was caring for her as her partner/husband.

11.23. Helen's invisibility from society, caused by her protected characteristics and the Perpetrator's coercively controlling behaviour, led to her death being undetected for nearly three years.

12. Background Information

12.1. The following information was shared with the Independent Chair by the Helen's family and her close friend Sally who had been friends with Helen for many years. Some of the descriptions in this section include opinions and perception of events rather than proven facts.

12.2. Helen's family told the Chair that she was funny, kind, bossy, stubborn, loveable, friendly, and happy. Helen "absolutely loved life". Helen was a very good, kind, and a respected nurse. Helen loved her dogs, loved shopping and liked being around people. Helen was independent and did not like being fussed over.

12.3. Helen and the Perpetrator met at work when they were in their twenties. Helen was the Perpetrator's mentor when he started as a student nurse and was a couple of years older than him. Helen's friend Sally had worked in the same organisation as both the Perpetrator and Helen for many years. They described how the Perpetrator was well known throughout the organisation as a "ladies' man" and had affairs at work which everyone knew about. Those who worked with Helen thought from the beginning that the Perpetrator was taking advantage of Helen.

12.4. Helen and the Perpetrator continued to work for the same health service for many years. Helen's friend explained that the Perpetrator had been frequently promoted, with Helen taking side steps in her career to ensure they were not on the same team.

12.5. In 1994, when applying to emigrate to Australia with the Perpetrator, Helen found out that she carried the Huntington's gene. All of the family told the Chair that Helen took this on the chin, called her family to let them know, and then took each day as it came. She continued to socialise, she enjoyed a glass of wine and loved the annual summer family barbeque, where she would still have a turn on the bouncy castle.

12.6. By around 2008, the Huntington's was becoming more visible, which is evidenced in the neurologist reports. Helen's sister told the Chair that around this time Helen started to find it difficult carrying food or drink from the kitchen to the table. She would need help getting in and out of the bath. She had some falls, for example when walking the dogs.

12.7. Helen and the Perpetrator separated in 2011 – their house was sold, and the profits shared, as evidenced in the financial report provided by Norfolk Constabulary. The family members confirmed that Perpetrator stayed in touch with Helen whilst they were living separately. The family told the Chair that in 2016 the Perpetrator and Helen appeared to get back together, with Helen moving into Westbrook Place which the Perpetrator had been renting out in a rural part of Norfolk.

12.8. The Perpetrator was described by Helen's family as "smarmy and aloof."

12.9. Helen's friend, who had worked with her since they both qualified in the early eighties, described how she was concerned about the Perpetrator from the beginning of their relationship. She did not suspect he could be violent but recognised his coercively controlling behaviour – although she was clear that this is a term she had only recently learnt. Until recently, when she learnt about the term coercive control through training at work, she recognised him as being narcissistic.

12.10. Helen's friend said that Helen would tell her that she had no choice but to pay for everything within the relationship. The Perpetrator liked to have designer clothes and Helen subsidised this lifestyle. Helen's friend tried to advise her that this was not a healthy relationship, but she said that Helen was possibly embarrassed, and would say "who would believe me?" so did not reach out for professional support.

12.11. Helen's sister explained that no-one had liked the Perpetrator from the start. He had only been to Helen's sister's house once, and when Helen's sister and her husband went to visit Helen over the years, the Perpetrator would go out, or make it uncomfortable for them so they would leave. He would never come to the family parties, he would drop Helen off outside and then come to pick her up, waiting on the roadside, and never coming in.

12.12. Helen's brother had met Perpetrator twice in thirty years, he said that the Perpetrator was hard work to speak to and that he had a high opinion of himself. Helen's nephew had met Perpetrator on more occasions as both him and his partner worked within the same health service as Helen and the Perpetrator, and for a short while they played on the same cricket team. He described the Perpetrator as overly friendly but acted superior around other people. He also said that the Perpetrator did not want to socialise with Helen's family, he did not attend any events with Helen and often she would attend alone or just would not attend.

12.13. All of the family described how following their separation in 2011, Helen was back to her affectionate and bubbly self. She moved into her own bungalow and re-engaged with her family. This was until Helen moved into Westbrook Place in 2016, where two years later she was murdered.

13. Chronological Overview

13.1. The information in the following sections has been gathered from chronologies provided alongside IMRs.

13.2. Helen trained as a General Nurse during the early 1980s. In 1988 she retrained as a Mental Health Nurse, a role which she stayed in until she was medically retired due to the symptoms of Huntington's Disease.

13.3. When the Perpetrator trained as a mental health nurse, Helen was his mentor. They soon began a relationship, and lived together in nurses' accommodation, until they purchased their own home in 1990.

13.4. Around 1994, Helen and the Perpetrator were planning to emigrate to Australia. As part of the process for emigration, candidates must undergo a medical examination process, which includes tests for genetic disorders such as Huntington's Disease. It was identified at this point that Helen carried the faulty gene which would lead to Huntington's. She was therefore not permitted to emigrate.

13.5. In 2003 Helen and the Perpetrator moved into a larger property in another part of Norfolk.

13.6. In 2007 Helen was formally diagnosed with Huntington's Disease.

13.7. The couple separated in late 2011. The reason the Perpetrator gave police for this was a gradual deterioration because of Huntington's making the relationship difficult. The family told the Chair that the Perpetrator was continuously unfaithful and had well publicized affairs with people at work, which Helen grew tired of and left him.

13.8. Following the separation, the house was sold, and each took a share of the proceeds.

13.9. The Perpetrator took redundancy during a restructuring in November 2012 and received a lump sum redundancy payment totaling over a year's salary.

13.10. During 2012 Helen moved in with her niece's family, and around the same time she took early retirement from nursing due to her deteriorating health.

13.11. In January 2013, Helen registered with Practice B, and was living in a bungalow on her own. On GP registration forms, she named her friend Jill as her next of

kin. She remained registered at Practice B until March 2016 when she registered at Practice A.

13.12. During 2013-2015, Helen's family told the Chair that the Perpetrator stayed in contact with Helen, turning up for visits which Helen called her "prison visits".

13.13. The Perpetrator told police that in 2014 Helen asked him to attend a neurology appointment at CUH with her– and stated that she told him she was finding life difficult on her own.

13.14. In March 2015, Helen applied for Personal Independence Payment (PIP),[21] there was a home visit to assess this application two months later where it is recorded that her friend Jill was also in attendance. Following the assessment, Helen was awarded a standard rate of payment for care and mobility with a review date in 2018. Payment was made directly into Helen's bank.

13.15. In July 2015, Helen contacted Norfolk County Council's Adult Social Care Department for a care assessment. She cited deterioration of Huntington's. Helen is noted as requesting a discussion about sheltered accommodation. An assessment was carried out by an Assistant Practitioner (AP). She was recorded as having some falls due to the "jerky" movements of the Huntington's and some cognitive issues including memory loss and word finding. Helen is recorded as functioning well and had the support of her friend Jill. Helen was not assessed as having unmet needs under the Care Act.[22]

13.16. A referral was made to Occupational Therapy, and on 23rd September 2015, the OT attended Helen's bungalow. Jill was at this meeting – Helen requested that Jill be point of contact for agencies as Helen trusted her implicitly. Helen described her symptoms as worsening over the past year and that she was attending neurology at CUH every six months. Helen was prescribed anti-depressants for variable feelings of low mood and anxiety. It is recorded that she had some speech difficulties which worsened with tiredness and had difficulty with swallowing. She was working with a Speech and Language Therapist (SALT). The OT noted Helen as being a determined and "very private" woman who wished to remain independent for as long as possible. It is also noted that the Perpetrator provided some support and Helen occasionally stayed with him for weekend breaks – he is recorded at this stage as an "ex-partner." Helen stated that she felt isolated from family and friends because of her location and wanted to move into sheltered accommodation closer to Jill. The OT provided equipment and wrote a letter in support of a move to sheltered accommodation.

13.17. On 8th October 2015, Jill contacted adult social care to confirm that the perching stool had arrived, and that Helen had received the letter of support from the OT

[21] PIP is paid to people who have long term health conditions, and have difficulty doing certain tasks or getting around:
Personal Independence Payment (PIP): What PIP is for - GOV.UK (www.gov.uk)
[22] 2014

for housing. Helen had met with the housing officer and had been advised that if she applied for sheltered housing, she would be considered low priority as she was not faced with homelessness. The AP ensured that Jill was aware of how to contact adult social care if Helen needed further support, and the referral was closed.

13.18. In December 2015, Helen was seen at the local hospital department of dietetics for a routine dietician appointment – her appetite was recorded as being good and she was given a review appointment for a year's time. Helen also had a swallowing assessment, which appeared stable. Helen did not report any communication difficulties. She was discharged from speech and language services at this point.

13.19. In early 2016, Helen moved to Westbrook Place. She registered with Practice A on 29th February 2016, however the family were unclear of the actual date she moved in with the Perpetrator as she had stayed there "for a short break" and then did not return to her bungalow.

13.20. The Perpetrator told police that at this time, he'd suggested Helen visit his property for a break for a few weeks, and that she ended up living there permanently.

13.21. On 29th April 2016, a payment was made from Helen's account into the Perpetrator's entitled "rent" – at this point the Perpetrator's bank account balance stood at around £500. Payments continued from Helen's account into the Perpetrator's account continuously until the Perpetrator was arrested and subsequently took his own life.

13.22. In April 2016, Helen had a medication review at Practice A – reported poor sleep for many years and mentioned that she had moved from her bungalow in Town B to "local adapted housing".

13.23. In May 2016, Helen was seen in the local hospital department of dietetics for a routine dietician appointment, no concerns were raised.

13.24. On 13th July 2016, Helen attended her neurology appointment at CUH – she advised her neurologist that she was feeling relatively well with some weakness in her arms and legs. Her independence score was 80% meaning that pre-disease level of work or employment may have been adapted or ended, household chores could no longer be performed to pre-disease level, and she may need help with finances.

13.25. On 15th August 2016, Helen was seen at Practice A for a medication review. Her mood is recorded as stable.

13.26. On 6th October 2016, Helen had her flu vaccine.

13.27. On 1st November 2016, Helen contacted the DWP for a PIP review as she had fallen down the stairs a couple of weeks before. She stated that she was unable to look after herself and her "husband" did everything for her. A review form was sent out and returned completed to the DWP on 1st December 2016.

13.28. On 21st December 2016, Helen is seen by neurology at CUH and states that over the past five months her symptoms had become worse, making her unsteady on her legs. She described a fall in the middle of the night. The Consultant recorded that she had early features of Huntington's with a little bit of involuntary muscle movement. There was a four-month review date set and Helen was referred to physiotherapy and a request is made to her GP for some medication to manage the unsteadiness. The GP commenced this medication immediately.

13.29. On 17th January 2017, a PIP home visit was undertaken. The Perpetrator was present, and Helen referred to him as her partner. Following this assessment, her PIP award was increased.

13.30. On 27th January 2017, Helen attended the dietician appointment, where it is recorded that she had gained over 2kg of weight and reported to have an improved appetite. It is recorded that she was "living with partner who cooks meals and ensures fortification."

13.31. On 26th April 2017, Helen attended CUH neurology appointment where it is noted that she now lives with her partner. It is recorded that she is independent with personal activities of daily living, but he does most of the household chores – and Helen no longer drives. Her independence score was 70% meaning that household duties such as cooking and using knives would be limited, and driving was no longer possible, at this point she is unable to manage her own finances. Following this appointment, the neurologist sent a request for medication change to the GP Practice.

13.32. On 11th May 2017, Practice A arranges a blood test for Helen, ahead of starting the new medication. Helen was then seen by the GP on 25th May and 1st June 2017 regarding raised cholesterol and her new medication commenced. There was a three-week telephone check set, to discuss progress with the new medication and a three-month review set for the cholesterol check.

13.33. On 14th June 2017, the Perpetrator claimed Carer's Allowance. This was awarded and paid from 19th June 2017 – with the first payment being issued on 14th August 2017.

13.34. A GP telephone review was undertaken with Helen, on 22nd June 2017, and no issues reported regarding the new medication.

13.35. On 15th July 2017, Helen attended Helen's great niece's 21st birthday BBQ at Helen's niece's house. She is described by her family as being in good spirits and enjoying herself. The Perpetrator had dropped her there, and did not go into the house, Helen's Nephew and his partner dropped her home to Westbrook Place.

They told the Chair that Helen showed them around the house and that Perpetrator was frosty and unwelcoming. This was the last time that any of the family saw Helen.

13.36. On 29th August 2017 Helen's nephew called Adult Social Care on behalf of Helen. He stated that his aunt was neurologically impaired by Huntington's Disease and had phoned him asking for help to find an alternative place to live because she believed that the Perpetrator was using all her money, he made her pay for everything, and Helen's nephew was concerned that the Huntington's was making her more vulnerable to financial exploitation. Helen had told Helen's nephew that she paid all the bills and the rent for Westbrook Place. Helen's nephew explained that Helen and the Perpetrator had split up following Helen's diagnosis but that 18 months ago they had got back together, and Helen had moved into the Perpetrator's property. Helen said that the Perpetrator does not take her out anywhere, as he is embarrassed that she looks drunk. An Assistant Practitioner contacted Jill, who Helen had named as her preferred contact. Jill stated that Helen had not told her of the concerns and gave examples of when Helen had been taken out of the house.

13.37. On 30th August 2017, the Assistant Practitioner again spoke with Jill – who confirmed that Helen's nephew had also called her the previous day to raise concerns. The Independent Chair spoke to Jill about this situation, and she confirmed that she would see Helen every week, and when she next saw Helen, she asked her if she was ok. Helen stated she was safe, and that she did not know why she had called her nephew with this concern. The Assistant Practitioner called Helen, who agreed to answer "yes and no" questions as the Perpetrator was present in the room. She did not want to raise any concerns, and said she was having a bad day when she called her nephew – following this call, the adult social care involvement ended.

13.38. On 5th October 2017, Helen attended Practice A for her flu vaccine.

13.39. On 11th October 2017, Helen is seen at CUH neurology appointment. The notes state that she was seen with her "husband". Helen stated no major changes in the past six months, and a review date was set for a further six months. Her independence score remained at 70%.

13.40. On 24th April 2018, Helen was seen at her neurology appointment. It is recorded that she was "with her other half". Helen reported to have remained well since the previous appointment, and her partner confirmed this. No falls and her weight was stable. Her independence score was 60%, and a review date was set for eight months.

13.41. On 14th May 2018, Helen was seen at her GP Practice for a medication review, with her "partner". She was reported to be well on her current medication. Her weight was stable and there were discussions about her ceasing smoking.

13.42. Between June and August 2018, repeat prescriptions were requested via the online system each month, these were all issued.

13.43. On 13th September 2018, Helen met her friend for lunch.

13.44. On 6th October 2018, Helen attended Practice A for her flu vaccine.

13.45. On 19th November 2018 a further online request was made for Helen's repeat prescription.

13.46. On 5th December 2018, Helen's friend received a text message from Helen's phone cancelling their lunch date.

13.47. On 12th December 2018, Helen failed to attend her neurology appointment. There is no record that Helen or anyone else had called to cancel the appointment, and no record that anyone contacted Helen to follow up. A further appointment was sent out in a letter for 4th March 2019.

13.48. On 8th January 2019, a request was made for Helen's repeat prescription, which was issued. This was not requested via the online system as had been the usual format; the practice can only confirm it was either by letter or by phone. A further request was made and issued on 5th February 2019, this flagged a task for the GP to call Helen in for a medication review. A message was left for Helen on her phone, to attend the surgery for a review. When she did not do this, the task was marked as completed. No further prescription requests were made, and there were therefore no further flags raised for a medication review. No further contact attempts were made with Helen regarding this.

13.49. On 28th February 2019, the Perpetrator was sent a text from Practice C inviting him for a Chronic Obstructive Pulmonary Disease (COPD) review. This was followed up by a phone call on 19th March and a further text message on 7th May 2019. Perpetrator contacted the practice on 22nd May 2019 and requested that no further COPD reviews be sent to him.

13.50. Helen did not attend her neurology appointment at CUH on 4th March 2019.

13.51. On 4th December 2019, Helen did not attend Practice A for her annual flu vaccine invite.

13.52. On 11th December 2019, the Perpetrator attended Practice C for his flu vaccine.

13.53. On 12th and 16th March 2020, the Perpetrator requested a repeat prescription for an inhaler and had a medication review.

13.54. National Covid-19 restrictions began on 23rd March 2020.

13.55. On 2nd April 2020, Helen was sent a cervical smear final recall.

13.56. On 1st May 2020, the Perpetrator undertook a telephone consultation for an asthma review. The notes indicate that he had started smoking again.

13.57. Between June and December 2020, a monthly prescription for the Perpetrator's inhalers was sent to a pharmacist in another County at the request of the Perpetrator.

13.58. On 7th October 2020, Helen was invited to book a flu vaccination appointment. No appointment was booked.

13.59. On 9th December 2020, an invitation was sent to Helen by Practice A, for breast neoplasm screening. Helen did not respond.

13.60. During December 2020, the Perpetrator was spoken to, or seen, by his GP Practice on three occasions, for blood pressure review, asthma review and for a blood test.

13.61. On 11th January 2020, the Perpetrator had a telephone appointment to discuss his high blood pressure, he told the GP that during the last year he had been drinking more than he should have and had gained weight. He was given lifestyle advice, and a review was set for three months.

13.62. On 28th January 2021, Helen was invited to book a flu vaccination appointment. No appointment was booked.

13.63. On 15th February 2021 a text message was sent to Helen, inviting her into the surgery for a covid-19 vaccination. This was followed up by a phone call on 1st March 2021, and a voicemail was left for her.

13.64. On 15th March 2021, the Perpetrator attended Practice C for his first covid-19 vaccination.

13.65. On 18th March 2021, the Perpetrator was seen at the local accident and emergency department as he had dislocated his shoulder following a fall at home. He had two follow up appointments with a physiotherapist before being discharged due to non-attendance on 22nd April 2021.

13.66. On 22nd June 2021, the Perpetrator had a telephone asthma review consultation.

13.67. On 1st July 2021, Practice A ran a computer search to identify which patients were not ordering their medication. Helen's name was flagged, which resulted in a decision to stop further issues of medication. No further action was taken.

13.68. On 13th September 2021, Helen was invited to book a flu vaccination appointment. This was followed up on 15th September 2021 as she had not booked an appointment.

13.69. On 21st October 2021, Helen's nephew contacted Norfolk Constabulary with concerns about Helen. Helen's niece and great niece had been to Westbrook Place the day before and had been told by the Perpetrator that Helen had moved away 18 months previously, to live with a friend, who the family had not heard of. Helen's nephew told police that the Perpetrator had been controlling in the past, with concerns about economic abuse, and Helen would need a carer wherever she was living due to Huntington's Disease.

13.70. Following Helen's niece and great niece's visit to the house, the Perpetrator sent a text message from Helen's phone, purporting to be Helen, stating that she was ok and had just started new medication which meant she couldn't speak to them.

13.71. Police conducted background enquiries and could not find an alternative address for Helen. On 24th October 2021 police visited the Perpetrator at home. He told them that Helen had moved out in June. A formal missing person's report was created for Helen on 25th October 2021.

13.72. On 27th October a strategy meeting was held involving police and health professionals including Practice A and CUH. This meeting determined that it would be very difficult for Helen to be living in the country with Huntington's without any sign of her on medical records since her last known appointment in October 2018.

13.73. On 28th October 2021, a murder investigation commenced. On 30th October Perpetrator was arrested on suspicion of Helen's murder, and on 1st November he provided a written statement admitting that he was responsible for Helen's death.

13.74. Over the next few days Police searched the grounds of Westbrook Place and located the remains of Helen's body.

13.75. The Perpetrator was found deceased in his prison cell on 29th December 2021.

14. Analysis

14.1. It is clear from the chronology above, that although there were never any obvious signs of physical violence in the form of injuries and Helen did not formally disclose abuse to any professionals - she had been living with a coercively controlling man.

14.2. Although she had not reached out for help from professionals, Helen had discussed the Perpetrator's behaviour with her friend Sally – who upon speaking with the Chair, had reflected on these conversations, following her own raised awareness of domestic abuse, and believed his behaviour to be coercively controlling.

14.3. Helen had also disclosed issues of financial abuse to her nephew in August 2017, only a short time after spending the day with the family at her niece's birthday party. On this occasion, Helen's nephew and his partner had dropped Helen off to Westbrook Place, and this had been the last time that any of the family had seen Helen in person.

14.4. The Perpetrator's isolation of Helen was made easier by her Huntington's Disease, however he exacerbated this isolation by placing her in a home which was miles from anywhere, by making it awkward for her to visit friends and family, by making it awkward for them to visit her, and by dwindling away her savings and income on his lifestyle, which Helen's family described as extravagant.

14.5. Professor Evan Stark - one of the architects of the Coercive and Controlling Behaviour offence[23] - describes coercive control as being "invisible in plain sight".[24]

14.6. Stark introduces the concept of a "cage" in which the abused subject is caught. He warns that until the nature of the cage is identified, practitioners will not be able to aid the victim in escaping. He states: "[the] barrage of assaults, the locked door, missing money, rules for cleaning, text messages…[are] recognised as bars."[25] Abuse of this nature – the "cage" - is not visible to those outside of the private family domain.[26]

14.7. Marianne Hester describes coercive control as a "long thin offence." She explains that abusers often do not stand around with blood on their hands waiting to be arrested and victims do not always present to professionals with visible injuries.[27] Coercive behaviours can be subtle and tend to be particular to the individuals in the relationship. Stark defines this as an "individualised package of behaviours developed through a process of trial and error for the victim by the person who knows her most intimately."[28]

14.8. The point where Helen's gender and disability intersected, is the point where she was at her most vulnerable. Her relationship with the Perpetrator had started before Huntington's was diagnosed, and before she was symptomatic, yet at this point the Perpetrator was already described by those the Chair spoke to, as narcissistic. Once her symptoms began, her dependency on the Perpetrator, his isolation of her, and in turn her risk levels – all rose. Thiara, Hague and Mullender have argued that support services often do not recognise the intersectionality of domestic abuse and disability, and the resulting "complex

[23] S.76 Serious Crime Act 2015
[24] Stark E *Coercive Control: How Men entrap Women in Personal Life* (2007) p.13
[25] Stark, above n 15 p.198
[26] *Ibid* p.14
[27] Hester, M *Domestic Abuse Masterclass: Thames Valley Police* (October 2013) Cited in Monckton Smith, J, Williams, A and Mullane, F *Domestic Abuse, Homicide and Gender: Strategies for Policy and Practice* (2014) p.17
[28] Stark, E above n 15 p.206

nature of women's abuse experience" – with each service provision not being set up to respond at the intersection.[29] Helen was not asked about domestic abuse when she accessed health provision, she was not responded to adequately when her nephew reached out on her behalf to adult social care, she was never given information – nor accessed – domestic abuse services.

14.9. As introduced above, Helen's Huntington's Disease placed her in a dependent position, where she was reliant on the care of the Perpetrator. Research shows that women with disabilities are at particularly high risk of abuse, from violence but also from abuse that targets their disability.[30] In Helen's case, this is evidenced in the financial abuse she experienced, with the Perpetrator spending her savings on his lifestyle, which was potentially made easier for him by Helen's lack of ability around money management. This is a factor of Huntington's which her family described to the Chair, and which was recorded on the neurologist's notes for Helen as being an issue for her.

14.10. The Perpetrator moved Helen into his home, at the point where he was about to run out of money. Whether Helen saw this move as a reconciliation with the Perpetrator, or whether she viewed it as the supported accommodation she had indicated to the local authority that she needed; the timing of this move, and the subsequent bank transfers from her savings into his account was an act of financial abuse which was largely invisible and which continued after Helen's death.

14.11. Helen appeared to be aware of the financial abuse by August 2017, when she called her nephew for assistance. Helen's nephew contacted ASC to report his concerns about Helen, and as will be discussed below, this was a missed opportunity for the financial abuse to be made visible.

14.12. The following sections will begin with individual agency analysis and will be followed by an analysis of overarching themes which have emerged from the review.

14.13. <u>Cambridge University Hospitals NHS Foundation Trust</u>

14.13.1. Helen attended the Huntington's disease clinic at CUH. She was generally seen by a specialist neurologist.

14.13.2. Also present at the CUH Huntington's disease Clinic is the Huntington's disease Association (HDA). This is a charity covering England and Wales, providing care and support services for people with Huntington's Disease. The HDA also

[29] Thiara, R, Hague, G and Mullender, A "Losing out on both counts: Disabled Women and Domestic Violence" *Disability and Society* 20 (6) (2011) and Hague, G, Thiara, R and Mullender, A "Disabled Women, Domestic Violence and Social Care: The Risk of Isolation, Vulnerability and Neglect" *The British Journal of Social Work* 41 (1) (2011)

[30] Plummer, SB and Findlay, PA "Women With Disabilities' Experiences with Physical and Sexual Abuse: Review of Literature and Implications for the Field" *Trauma, Violence and Abuse* (2012)

provides emotional support to patients, to people at risk of Huntington's, family members, carers, friends, neighbours, and employers. There is a record of Helen speaking to the HDA advisor, but nothing recorded regarding disclosures or concerns of abuse.

14.13.3. There is no evidence in Helen's CUH electronic medical records of any disclosures or suspicions of domestic abuse or safeguarding concerns. There is no indication from the specialists who Helen saw that they had concerns about Helen's mental capacity to make decisions.

14.13.4. There are reports in the notes at the clinic appointment on 21st December 2016, of a fall down the stairs in the middle of the night. Helen had previously reported falls which is not unusual in a patient who has Huntington's. With the benefit of hindsight consideration should have been given to the context in which the fall occurred; it is not clear if there was a fuller discussion with Helen about this fall.

14.13.5. There was no follow up with Helen, following her failure to attend an appointment on 12th December 2018. Helen was sent a new appointment for March 2019, and when she did not attend this no further action was taken. When speaking to the IMR writer, the Neurologist confirmed that unless there are specific concerns about a patient, then no further appointments will be booked.

14.13.6. The Did Not Attend policy which was in place during 2018/2019 did not specify the action to be taken when a patient does not attend a specialist clinic. The review of this policy will form a recommendation for CUH.

14.13.7. CUH specialist clinics do not have a policy regarding routine enquiry around domestic abuse. Considering the vulnerabilities of patients with degenerative illnesses such as Huntington's as described in the section above – it would be prudent to require specialists, or administrative staff, to ask patients a small number of simple questions regarding their relationships. Without asking questions about abuse, it can be difficult to identify abuse.

14.14. <u>Norfolk and Waveney Integrated Care Board – Primary Care</u>

14.14.1. Helen registered with Practice A in March 2016 when she moved into Westbrook Place with the Perpetrator.

14.14.2. There was good communication between Practice A and CUH, with a report provided to Practice A following each attendance at the clinic.

14.14.3. However, as there was no concern raised by CUH following Helen's failure to attend the clinic in December 2018 and again in March 2019 – Practice A were not informed of Helen's non-attendance at the neurology clinic.

14.14.4. A prescription request was made for Helen's repeat medication in January 2018. As her medication was not yet due to be reviewed, a further one-month supply was issued. It is not possible to determine who made this request and collected

it from the practice dispensary, as this information is not recorded – however it is assumed that this was the Perpetrator, as this date was after Helen had been killed.

14.14.5. A further medication request was made on 5th February 2019. At this point Helen's GP sent a task to the administrative team to call Helen in for a medication review. She was sent a text, and a voicemail was left on her mobile phone – however Helen did not respond to these messages and the task was closed. The IMR writer spoke to Practice A staff who indicated that this would be routine practice. However, upon reflection, the practice identified a learning need, for the named GP to be made aware if medication reviews are missed.

14.14.6. There were no further medication requests after February 2019 – presumably as the Perpetrator knew that this would draw attention to Helen's disappearance. As no further medication requests were made, no further medication reviews were requested – and no concerns were raised as to Helen's lack of medication. This was a missed opportunity for Practice A to consider why Helen was no longer requesting her medication.

14.14.7. The GP Practice could have liaised with CUH, which would have flagged with both services that Helen may not have been accessing health care provision, which she had never previously missed.

14.14.8. At a reflective safeguarding meeting held at the Practice in February 2022, it was raised that Helen had been flagged during a routine audit of patients not ordering their repeat medication which was completed in July 2020. This resulted in further repeat medications being stopped by Practice A dispensary – however there was no procedure in place to inform Helen's named GP of this. Neither was any professional curiosity employed to consider why repeat medication had abruptly stopped being requested.

14.14.9. The British National formulary (BNF) is a United Kingdom pharmaceutical reference book that contains information and guidance on prescribing and pharmacology available on the UK National Health Service. The BNF states that abrupt cessation of venlafaxine (one of the medications prescribed to Helen) is:

"associated with a higher risk of withdrawal effects compared with other antidepressants. Gastro-intestinal disturbances, headache, anxiety, dizziness, paraesthesia (burning or prickling skin sensation), tremor, sleep disturbances, and sweating are most common features of withdrawal if treatment stopped abruptly or if dose reduced markedly; dose should be reduced over several weeks." [31]

14.14.10. The Perpetrator was registered at Practice C from July 2016. He first raised his mental health issues with his GP in October 2021 during a telephone consultation, where he reported feeling depressed for several months. He

[31] BNF (British National Formulary) | NICE accessed 20th April 2022

reported isolation due to Covid-19 restrictions, and stated he had been drinking too much, waking early in the morning, and had no pleasure in life. His GP completed a risk assessment, identified no suicidal or self-harm thoughts, and he was diagnosed with depressive illness and commenced on anti-depressant medication. Practice C had no further contact with the Perpetrator before he was taken into custody, and he later died whilst in custody.

14.14.11. Practice A did not identify Helen as a vulnerable adult and therefore did not include her in their vulnerable adult register. The practice criteria for this list includes frail elderly patients, safeguarding cases or those with a known risk or obvious vulnerability such as a learning disability. The safeguarding lead GP has identified that the criteria for the vulnerable adult list could be widened to include patients with long term conditions receiving specialist input as this would ensure notes are reviewed and discussed with practice colleagues monthly and would encourage professional curiosity.

14.14.12. Both Practice A and Practice C have lead and deputy safeguarding clinicians. At the time of writing the IMR, Practice A did not have a domestic abuse champion or domestic abuse policy. This was identified as a recommendation for the Practice.

14.14.13. It is widely acknowledged that asking individuals about domestic abuse is more likely to encourage disclosures.[32] It would be good practice for health practitioners to routinely ask a simple set of questions regarding risk and/or harm of domestic abuse.

14.15. Adult Social Care

14.15.1. Helen's involvement with Adult Social Care (ASC) in 2017 broadly involved two social care roles:

- *Social Care Community Engagement Assistant Practitioner (AP)* – this role is situated in the ASC front door service (See Glossary). The AP responds to calls which come into the Customer Service Centre (CSC), and which are passed through to SCCE. Calls will have been triaged by a manager for urgency. The AP will gather further information and can make assessments under the Care Act for some low complexity cases. They gather details and put cases through to locality teams where the situation is more complex and needs a face-to-face visit and these decisions are made under the supervision of a manager. They provide advice, information and signposting. They take safeguarding referral information and discuss with managers and SAPCs about whether s42 enquiries are needed.

[32] O'Keeffe, M and Marchant, G *Leeds Routine enquiry: GPs and Health Practitioners in 8 Practices in Leeds: evaluation report 2019* Leeds Clinical Commissioning Group (2019)

- Safeguarding Adults Practice Consultant (SAPC) – this is a senior social worker post, which offers consultation and management overview for safeguarding cases, to frontline staff in both the Social Care Community Engagement Team (SCCE) which is Norfolk ASC's front door service, and locality teams.

14.15.2. During 2015-2017, the CSC was managing the front door service. The CSC deals with calls pertaining to all local authority departments. Calls from members of the public or professionals were received into the CSC and a Customer Service Assistant would carry out a system check and then pass the call to the SCCE if there was no allocated worker in the adult social care department. When the call was received in SCCE, an AP was allocated to call the referrer back to gather more information.

14.15.3. CSC released one AP per day to sit with the SAPCs in the Multi-agency Safeguarding Hub (MASH – see glossary) and this AP would take many of the safeguarding calls with overflow calls being taken by other safeguarding-trained APs in SCCE. If there was a safeguarding element to the call it would be allocated to an AP who had been trained to deal with safeguarding cases who could either be sitting with MASH or sitting within SCCE. Once the AP had gathered information, they would contact the MASH SAPC for a consultation and advice/guidance on further actions.

14.15.4. Adult social care received a self-referral from Helen, via a phone call, on 30th July 2015 requesting a care needs assessment and an occupational therapy (OT) assessment. She also advised that she was considering moving to sheltered accommodation. Helen was living in a shared ownership bungalow at the time.

14.15.5. Following the self-referral, an assessment was carried out by an AP and Helen's Huntington's disease was identified at this time as a condition which affected her day-to-day functioning. Helen explained that her body experienced "involuntary jerks", which sometimes led to falls. She was also recorded as having some cognitive issues including memory loss and some problems with processing and word finding. Despite her condition, Helen stated that she was functioning well at this time with the support of her friend Jill and was not assessed as having unmet needs under the Care Act.

14.15.6. It was identified by the AP that due to the risk of falls; Helen would benefit from a community alarm. A perching stool was also provided, and a letter was written in support of her move to sheltered accommodation.

14.15.7. The District Council housing department no longer hold information about the enquiry made by Helen in 2015. This is due to their retention policy requiring that single contacts with no risks identified be deleted after five years. The District Council informed the panel that Helen would have been advised that she could apply for sheltered accommodation, but she would be deemed a low priority as she had no risk of homelessness. They also confirmed that if any

concerns been raised, or risks identified, the retention policy would have required the information to be retained – they would therefore surmise that no concerns or risks were identified.

14.15.8. In August 2017, Helen's nephew contacted adult social care with concerns about his aunt. At this time, Helen was considered to be a person with care and support needs - whether or not those needs were being met by the local authority – due to the degenerative nature of Huntington's Disease. Helen certainly had "an appearance of need" as defined in the Care Act. [33]

14.15.9. It appears that difficulties communicating with Helen had not been apparent at that time and were therefore not considered during the telephone call. The AP was interviewed by the IMR writer, and she could not recall the conversation with Helen, but said that she believes she must not have had concerns about Helen's communication during the conversation otherwise this would have been recorded. Helen may potentially have had difficulty in understanding what was being asked and responding although it is impossible to know given that the AP cannot recall the content of the phone conversation.

14.15.10. Following call made by Helen's nephew expressing concerns about financial exploitation and possible emotional abuse – this was passed to the AP who called Helen's nephew to discuss his concerns. Helen's nephew said that Helen had contacted him to ask for assistance in finding an alternative place to live, as she believed the Perpetrator was exploiting her financially.

14.15.11. During ASC involvement with Helen in 2015, it was recorded that she had expressed a wish for the department to communicate via her friend Jill due to her difficulties communicating over the telephone. The AP followed this request and contacted Jill, who confirmed that she had spoken to Helen's nephew the previous night and was surprised that Helen hadn't expressed any concerns to her. Jill called Helen and reported back that everything was ok, and that Helen did not raise any concerns. However, Jill mentioned that Helen may not have been able to speak freely if the Perpetrator was in the room.

14.15.12. The AP correctly sought advice from the more senior SAPC, who advised the AP to speak to Helen directly. The AP did so, however it is recorded that Helen was not able to speak freely as the Perpetrator was there. The AP recorded that she asked questions to which Helen could answer yes or no. It is unclear about what questions were asked and what responses Helen had given.

14.15.13. This situation highlights a lesson to be learnt regarding verbatim recording of conversations, especially if there is a concern about a person's ability to communicate and if questions requiring yes/no answers are being asked.

14.15.14. Helen may have had difficulty communicating and engaging on the telephone, particularly if the Perpetrator was present, but if she did, this was not identified.

[33] Care Act 2014 s.9(1)

The AP told the IMR Writer they assumed Helen would be able to communicate by telephone as she was in contact her nephew and Jill by telephone. ASC accept that it is possible Helen may have had difficulty engaging in a conversation over the telephone.

14.15.15. Helen's family told the Independent Chair that they were advised by ASC to call police if they had further concerns. There is nothing in the case files regarding the AP's subsequent actions following the call with Helen. When interviewed by the IMR writer, the AP was unable to recall the case to comment further, however noted that on LAS it is recorded that Helen would contact Adult Social care, her nephew or Jill if she had further concerns.

14.15.16. The SAPC was not able to recall the case but noted that the AP is not recorded as having returned to them for further guidance. The SAPC said that there had been an expectation at this time, that APs should add an observation to the CareFirst system (which was the system in use at the time) to document their conversation with an SAPC about further actions.

14.15.17. Since August 2017, the ASC safeguarding process has been updated, and the AP is sure that if this case happened now, they would have discussed the matter further with the SAPC. There is now a requirement to consult with an SAPC inbuilt into the process. However, this ongoing dialogue was not common practice in 2017.

14.15.18. The IMR writer asked the SAPC what their actions would have been at that time if the AP had fed back the outcome of the conversation with Helen. They said that given the alleged abuser was in the background when the AP contacted Helen, there would have been a concern that a discussion would have been unsafe, and efforts would have been made – maybe with the GP or with Helen's friend Jill – to establish a safe conversation with Helen, away from the Perpetrator.

14.15.19. The SAPC told the IMR writer they believed Adult Social Care's involvement had been ended too early, and the situation was too complex to have been closed when it was. They believed that a safe and full conversation was needed with Helen before any decisions could have been made about the next steps – including what information or advice was shared with the family.

14.15.20. The SAPC explained that a new process has been implemented which requires APs to notify SAPCs about the enquiries they have made and for the SAPC's advice to be recorded on LAS. In this respect there is much greater accountability in both decision-making and recording of decision-making.

14.15.21. ASC accept that there was a missed opportunity to engage with Helen more fully, to thoroughly explore the allegations raised by her nephew about financial and possible emotional abuse. It is felt that had the safeguarding concern included an element of physical or sexual abuse, the level of concern and intervention may have been higher in 2017 as this would have indicated a more

overt threat to Helen, but issues of coercion and control were less well understood at that time.

14.15.22. In 2017, ASC did not have a distinct Carers' Lead role and carer issues were not afforded the priority they are now. Since 2017 a Carers' Lead has been appointed and a service commissioned with Carers Matters Norfolk (CMN), to which adult social care staff can refer for carers assessments to be carried out. ASC had no contact with the Perpetrator, but it is noted that he may have had needs as a carer for Helen. While it would not have been appropriate to contact him directly, better engagement with Helen may have led to further assessment of her care and support needs as well as to making enquiries into the safeguarding concerns.

14.15.23. Under the current process, it is very likely that this case would have been sent directly to the locality team for a s42 enquiry which would include exploring options to have an unfettered conversation with Helen. Information would be shared with the police as part of the standard process when raising a safeguarding enquiry. ASC is now using the ADASS/LGS framework on Making decisions on the duty to carry out safeguarding enquiries which gives a clear steer about cases which must be taken to a s42 enquiry. This is a suggested framework and not statutory guidance and was published in 2019.

14.15.24. The SAPC said they felt that while services would still not be easily accessible to Helen due to her cognitive and communication difficulties, the safeguarding team now has a much more in-depth understanding of the risks associated with domestic abuse. They said that the team's understanding of domestic abuse had developed and evolved over the past five years, bolstered by an increase in staffing and a remodelling of how the team functions. They said that if there was potentially a risk, and the person's wishes could not be established, a safeguarding enquiry would be raised - either with or without the knowledge of the individual.

14.15.25. Adult social care was sensitive to Helen's wishes in relation to her nominated representative and followed the instructions Helen had given in 2015 by contacting her friend Jill in the first instance.

14.15.26. The SAPC correctly identified when Helen's own view should have been sought in 2017, however this was not followed through to a satisfactory conclusion. When Helen was contacted, it was unsafe for her to speak openly, and this was not escalated or followed up. However, since 2017, ASC processes have been improved and staff now undergo consistent domestic abuse training which includes safely enquiring about risks.

15. Conclusions

15.1. Covid-19 Restrictions

15.1.1. In March 2020, the United Kingdom was placed under a set of measures which restricted the movement of people – this was to reduce face to face contact in order to reduce the spread of the Covid-19 virus. [34]

15.1.2. These restrictions meant that health and social care appointments were moved either to the telephone or to a virtual space.

15.1.3. The terms of reference for this DHR included the question of how the Covid-19 pandemic restrictions effected mechanisms which may have been in place, that would follow up with Helen when she seemingly disengaged with services.

15.1.4. From the information provided by Practice A and CUH, Covid-19 restrictions did not have any bearing on the follow up process when Helen failed to attend appointments at CUH. She failed to attend her neurology appointment at CUH in November 2018 and March 2019, both dates being prior to the introduction of Covid-19 measures being introduced. Following the second appointment being missed no further action was taken.

15.1.5. In respect of Practice A – prior to pandemic restrictions, Helen failed to attend a medication review in January 2019, ahead of further repeat prescriptions being provided – a message was left on her phone, and no further action taken. Also, Helen failed to book her flu vaccination in December 2019, no further action was taken. Following the Covid-19 restrictions being in place, Helen failed to book flu vaccinations in October 2020, January 2021, and September 2021. Helen was also invited to book a smear test, a breast neoplasm screening and a covid vaccine whilst Covid-19 restrictions were in place.

15.1.6. In July 2021, Practice A undertook a computer search of patients who had not been ordering their medication. Helen was identified, and the outcome was that the surgery stopped further medication being ordered. No further action was taken.

15.1.7. There does not appear to be any evidence that the presence of Covid-19 restrictions impacted on mechanisms in place to follow up with Helen when she seemingly disengaged with services, as it does not appear that mechanisms had been in place to do this prior to the pandemic.

15.2. Routine Enquiry

15.2.1. A SafeLives study found that 85% of domestic abuse victim/survivors sought help five times before getting effective help,[35] and research by Agenda shows that victims and survivors of abuse want to be asked about their experiences of abuse.[36]

[34] The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (legislation.gov.uk)
[35] Getting it right first time - complete report.pdf (safelives.org.uk)
[36] Agenda *Ask and Take Action:Why Public Services Must Ask About Domestic Abuse* (2019) Ask and Act England (weareagenda.org)

15.2.2. A SafeLives initiative aims to transform health care's response to domestic abuse by ensuring a coordinated and consistent approach across the whole health system, from acute and primary care to mental health provision.[37] However the first step to providing support for a victim/survivor of domestic abuse, is to ask about the abuse.

15.2.3. Health professionals are uniquely placed to ask about domestic abuse[38] and over the past decade there has been a growing awareness of the need for proactive identification of abuse.[39] NICE have published recommendations for multi-agency responses to domestic abuse, which included ensuring that trained staff ask people about abuse.[40]

15.2.4. Safe enquiry projects and initiatives began in midwifery services,[41] and can now be evidenced in other services such as health visiting,[42] sexual health clinics[43] and paediatric settings.[44] Subsequent studies have found that brief questioning by professionals leads to higher rates of disclosure.[45]

15.2.5. However, in order for safe and routine enquiry to be successful, or indeed to happen at all, practitioners must be trained in domestic violence and abuse.[46]

15.2.6. There are currently initiatives across England and Wales which place domestic abuse specialists within health settings, for example Independent Domestic Violence Advisors within hospital settings[47] and the IRIS initiative[48] which partners GP practices with domestic abuse providers. These initiatives enhance the understanding of domestic abuse for those working within the

[37] Whole Health London – the importance of survivor voice. | Safelives
[38] Taket, A et al "Routinely asking Women about Domestic Violence in Health Settings" *British Medical Journal* (2003)
[39] Bradbury-Jones, C and Taylor, J "Establishing a Domestic Abuse Care Pathway: Guidance for Practice" *Nursing Standard* 6 (27) (2012)
[40] NICE *Domestic Violence and Abuse: Multi Agency Working* (2014) 1 Recommendations | Domestic violence and abuse: multi-agency working | Guidance | NICE
[41] Baird, K at al "The Bristol Pregnancy and Domestic Violence Programme An evaluation assessing its effectiveness in promoting the introduction of routine antenatal enquiry for domestic violence" *Midwifery* 22 (2005)
[42] Boddy, B "Newly qualified Health Visitor: Routine Enquiry and Disclosure of Domestic Violence *Journal of Health Visiting* (2020)
[43] Lyus, L and Masters, T "Routine Enquiry for Domestic Violence and Abuse in Sexual Health Settings" *Sexually Transmitted Infections* (2018)
[44] Asiegbunam, N "Introducing Routine enquiry about Domestic Violence in Paediatric Settings" *Archives of Disease in Childhood – Education and Practice* (2017)
[45] Baird, K et al "A Five-Year Follow Up Study of Bristol Pregnancy Domestic Violence Programme to Promote Routine ENQUIRY! *Midwifery* 29 (2008)
[46] Baird et al, K "effectiveness of Training to Promote Routine enquiry for Domestic Violence by Nurses: A Pre-Post Evaluative Study" *Women and Birth* (2018)
[47] Dheensa, S et al "From Taboo to Routine: A Qualitative Evaluation of a Hospital Based Advocacy Intervention for Domestic Violence and Abuse" *BMC Health Services Research* (2020)
[48] What is IRIS - IRISi

setting, therefore increasing rates of enquiry about domestic abuse, and they also provide a pathway to specialist domestic abuse support.

15.2.7. Helen was never asked about domestic abuse. CUH and Practice A did not raise a concern about Helen when she failed to attend appointments because there were no safeguarding concerns for her. If Helen had been asked about domestic abuse, especially in light of the fact that she reached out to her nephew for help, she may have disclosed the financial abuse when asked.

15.2.8. Embedding a safe and routine enquiry format within health care settings reduces the ambiguity of "professional curiosity" which can be subjective and manifest as something "over and above" a person's role description.

15.3. Holistic Understanding of Risk

15.3.1. Helen reached out to her nephew to disclose financial abuse, and in turn he approached ASC. From the information in the chronology, and the analysis sections above, it is apparent that ASC's response to this request for assistance could have been managed more proactively, instead of ending at the point where Helen stated she was fine, further conversations could have taken place between the AP and the SAPC.

15.3.2. It does not seem an overall assessment of Helen's needs were considered, namely how her illness exacerbated her situation. How her condition rendered her dependent on the Perpetrator and how it forced her to be in close proximity to him, so that she was unable to speak on the on the phone without him being there. Huntington's Disease affects cognitive functioning, including communication and decision making – which does not appear to have been taken into account.

15.3.3. Findings in Safeguarding Adult Review (SAR) "Hannah" – a woman with Huntington's Disease who was murdered - found that:

"an overall assessment of Hannah's needs should have taken into account her health conditions...there should have been a holistic understanding of risk."[49]

15.3.4. This was also found in SAR "Ben" – who was a male with Huntington's who died by suicide.[50] In both cases concerns had been raised about the risk associated with Huntington's symptoms leading to additional vulnerabilities – of criminality and of suicidality, but these had not been assessed holistically.

15.3.5. This can also be evidenced in the lack of follow up when Helen missed appointments with the Huntington's clinic at CUH. As described above at section 12 – people with Huntington's Disease are disproportionally affected by suicide. Taking this into account, the unexplained absence of a patient from the clinic

[49] 9ed9c741-5b66-6ae0-027c-1a19b66935f2 (camden.gov.uk)
[50] SAR-Ben.pdf (nationalnetwork.org.uk)

should require more of a response, such as a phone call to follow up, or liaison with the patient's GP to determine whether they had failed to attend elsewhere.

15.3.6. Another area which could have been followed up was Helen's failure to book vaccinations and screenings despite being invited to do so by her GP practice, and more concerning, when she stopped requesting and collecting medication. If Helen had been flagged as vulnerable – taking her whole risk into account - this may have prompted communication between the CUH neurology clinic and her GP practice, which may have flagged her absence from both health care settings – despite many years of consistent engagement with services.

15.3.7. The Perpetrator claimed Carers Allowance from 14th June 2014.[51] The application for Carers Allowance requires a carer to confirm that they provide care a disabled person for at least 35 hours per week. Upon receipt of Carers Allowance application, the DWP would contact the disabled person or their representative to confirm that at least 35 hours per week caring is taking place. If the disabled person is in receipt of a qualifying benefit, and they confirm that the applicant is caring for them for the required 35 hours per week, Carers Allowance will be awarded. There is no requirement for the DWP to routinely notify any relevant agencies of an award of Carer's Allowance.

15.3.8. Where concerns for the wellbeing or safety of a person who is claiming benefits or using DWP services are identified, the DWP would share information with other relevant organisations, however no concerns were raised with the DWP regarding either Helen or the Perpetrator.

15.3.9. Although the Perpetrator was in receipt of Carer's Allowance to support his caring duties, the Perpetrator was not known officially as her carer by other agencies, for example Helen's GP or the CUH neurology department. There was therefore no reason or opportunity for a carers assessment.

15.3.10. The Perpetrator was virtually invisible to the outside world, in respect of his role within Helen's life – although his role in her life was vital to any assessment of her risk levels.

15.4. Financial abuse

15.4.1. The Perpetrator subsidised his lifestyle with Helen's savings, her NHS pension, and the welfare benefits she received due to her condition. After she died, he spent over £35,000 of her savings, and continued to spend her private pension and welfare benefits totally around £80,000.

15.4.2. One in six women in the United Kingdom experience financial abuse[52] and 95% of women who are experiencing domestic abuse report experiencing economic

[51] Carer's Allowance: Eligibility - GOV.UK (www.gov.uk)
[52] Refuge (2020) Know-Economic-Abuse-Report-2020.pdf (refuge.org.uk)

abuse.[53] It is clear from speaking to Helen's family, and from Norfolk Constabulary's examination of Helen and the Perpetrator's bank accounts, that the Perpetrator was using Helen's money to fund his lifestyle. Considering the cognitive difficulties, she would have been experiencing due to Huntington's and considering the phone call that she made to ASC, it is likely that the acquisition of this money was without Helen's informed consent. Research shows that there is a lack of awareness about fraud and theft amongst families. Safeguarding partners often face a conflict between a patients' right to make unwise decisions, and statutory duties around protection.[54]

15.4.3. Helen was not identified by safeguarding partners as being at risk of coercive control, or financial abuse, however her circumstances can now provide an insight into how financial abuse can be perpetrated by people in a position of trust. By examining the financial position of Helen, and of the Perpetrator at the time he invited her to move in, it is clear to see that co-habitation was of great financial benefit to the Perpetrator. He had very little left of his share of the house sale, and his redundancy pay out, and as soon as Helen moved in, deposits began from her account into his, in the guise of "rent".

15.4.4. Helen's family told the Chair that the Perpetrator was flashy, that he wanted others to think that he was wealthy, and that they believed he lived above his means. Helen's saving facilitated this way of life, even after she was killed by the Perpetrator.

15.4.5. It is probable that the Perpetrator manipulated Helen's need for a carer, and her desire to move into sheltered accommodation - which was not forthcoming when she enquired with the local authority in late 2015 – so that during the early part of 2016, just as his own money was running out, he was able to move Helen in, claim carers allowance for himself and utilise her savings to fund his lifestyle.

15.4.6. As recorded on her neurologist's case notes, Helen would not have been able to manage her own finances, so the Perpetrator may have found it particularly easy to take over the management of her funds. Norfolk Constabulary's investigation into the Perpetrator's misuse of Helen's funds found that her own spending changed rapidly when she moved into his property.

15.4.7. From 2016 to 2017 when she moved in with the Perpetrator, Helen's personal spending reduced by nearly half, and in 2018 her spending reduced to less than a fifth of her usual spending. In the beginning of 2018, there was regular spending at supermarkets and in clothing shops, after June 2018 there is only one bill payment and three payments to a hairdresser. This pattern of spending offers an insight into her increasing isolation, where she does not appear to be

[53] Surviving Economic Abuse (2019) P743-SEA-In-Plain-Sight-report_V3.pdf (survivingeconomicabuse.org)

[54] Hawkswood, J and Brown, K *Theft and Fraud Within Families* Financial Vulnerabilities Task Force

spending money outside of the house, probably because she was not leaving the house.

15.4.8. Women who experienced economic abuse are five times more likely to experience physical abuse[55], and women who are experiencing coercive control, and economic abuse, are at increased risk of being killed.[56] It is therefore vital that agencies who encounter victim/survivors are knowledgeable about the signs, as well as the increased risks, of economic abuse. When Helen's nephew contacted ASC with concerns for Helen's welfare following her disclosure of financial abuse, this should have raised a red flag, especially considering her dependency upon the person she was making the allegation against. Helen's personal circumstances, alongside the possibility of economic abuse raised her risk level, and the response should have been in line with this risk.

15.4.9. To assist practitioners in understanding financial abuse, and possible responses available to support those affected by it, there is a financial abuse code of practice available for reference.[57] In May 2019, Norfolk Council established the role of a Financial Abuse and Safeguarding Officer. This role was introduced following the identification of need by the Adult Safeguarding Board and the local authorities adult safeguarding team.[58] The initiative has had a positive impact, providing staff with a route to raise concerns and queries about possible financial abuse. It can be assumed that if this role was in place when Helen's nephew called ASC with concerns about Helen being financially abused, there may have been a more proactive response.

16. Lessons to be Learnt

16.1. Agencies involved in the review identified learning which has already been implemented, or started, since Helen's death. These will be shared in the following section. Also, through the process of the review, the panel identified three key themes of learning which have informed the DHR recommendations detailed in section 17 below.

16.2. <u>Department of Work and Pensions</u>

16.2.1. DWP continually review their domestic abuse and violence guidance and it is easily accessible to staff via a Department for Work and Pensions wide intranet site.

[55] Outlaw, Maureen. "No one type of intimate partner abuse: Exploring physical and non-physical abuse among intimate partners." *Journal of Family Violence* 24.4 (2009): 263- 272

[56] Sharps-Jeff, N "How Economic Abuse is Experienced", *Understanding and Responding to Economic Abuse* (*Feminist Developments in Violence and Abuse*) (2022) pp. 71-100.

[57] Financial Abuse Code of Practice | UK Finance

[58] Hawkswood, J and Brown, K *above n 42* p.14

16.2.2. DWP has recruited Advanced Customer Support Senior Leaders (ACSSL) forming a Nationwide network of support that provides clear escalation routes for cases involving claimants deemed at risk of abuse, harm, and neglect.

16.2.3. Carers are provided with signposting when they make an application for carers allowance. The support available includes advice about financial support, assessments, available support services and carers' rights. This information is on the carers allowance entitlement letter they receive – and is also available on the gov.uk website.

16.2.4. This review has identified learning around the lack of recording of partners who are carers and claiming Carer's Allowance, by any agencies other than the DWP. The findings of this review could contribute to national learning and will therefore be shared with the relevant DWP Directorates, and the Domestic Abuse Commissioner's Office DHR Repository.

16.3. Cambridge University Hospitals NHS Foundation Trust

16.3.1. The Huntington's Disease clinic have reported that they are more proactive with clinic appointments now than they were during the review period. Staff will contact patients ahead of their appointments to check if they are able to attend. Appointments are now centralised and are no longer sent via the clinic or secretarial staff, ensuring records are held electronically.

16.3.2. When reviewing the Did Not Attend Policy for this review, the IMR author became aware that it was difficult to locate. She identified the need for a standalone "Missed Appointments" policy, which would also include "was not brought" as some patients are unable to bring themselves to appointments – this is in line with the policy for children and young people.

16.3.3. CUH have also been implementing plans for the introduction of Routine Enquiry, for all patients attending the Emergency Department, Assessment Units and Outpatient Clinics.

16.4. Norfolk and Waveney Integrated Care Board

16.4.1. Practice A identified that the named GP should be informed if medication is left uncollected from the practice dispensary, particularly where that medication should not be stopped abruptly, and/or if the repeat medication should not be ceased with the authorisation of the named GP. Once informed, the named GP would be able to make a clinical decision about next steps, for example attempting to contact the patient or their next of kin.

16.4.2. The practice also identified the need to ensure robust communication between the surgery and specialists in particular with respect to communication of medical problems and medication as was requested by the specialist on two occasions in this DHR.

16.4.3. GP practices should have both domestic abuse and safeguarding adult policies and should be encouraged to have a domestic abuse champion within the practice team.

16.5. Adult Social Care

16.5.1. Safeguarding practice has evolved since Helen's nephew contacted ASC in 2017 with concerns about Helen. Since then, there is much greater accountability for decision making and recording of decision making. There is also a much greater awareness of domestic abuse. The Care Act 2014 increased the focus on domestic abuse, by including it as a specific category of abuse. Awareness has been further strengthened by the Domestic Abuse Act 2021.

16.5.2. Early Learning from this review has already been shared with ASC staff to highlight the importance of following up concerns raised by family members in a safe way, including speaking to possible victims of abuse away from the alleged abuser, and understanding financial abuse.

16.5.3. Communications have been shared with all staff regarding the need to record conversations verbatim, when speaking with people who have communication difficulties, particularly when discussing risk and harm. This is to ensure it is clear what they were asked, and what their specific response was.

16.5.4. In 2017, ASC became a member of the Domestic Abuse and Sexual Violence Group (DASVG), a subgroup of which focuses on the specific needs of adults with care and support needs who are experiencing, or who are at risk of, abuse or neglect.

16.5.5. Until recently, domestic abuse has been covered within ASC's general safeguarding procedure, however since 2019 a standalone domestic abuse procedure has been implemented. The domestic abuse procedure recognises the unique complexities of domestic abuse, particularly for adults with care and support needs who are at risk.

16.5.6. In 2021, ASC carried out a learning review which led to an updated and refreshed training programme for staff. The updated programme includes understanding and identifying coercion and control, financial abuse and professional curiosity. The training content increases in complexity at higher levels.

16.5.7. The higher-level course "learning lessons from Safeguarding Adults Reviews" has been renamed to "learning lessons from Safeguarding Adults Reviews and Domestic Homicide Reviews" and will have a heavier focus on domestic abuse. The Making Safeguarding Enquires course covers making a safe enquiry when domestic abuse is an issue. All courses will address how coercion and control may affect a person's capacity to make decisions about their safety and what

to do if the person is at risk of harm. During 2022, ASC commissioned a specific standalone course for all staff on domestic abuse and coercion and control which is mandatory.

16.5.8. DASH training has been extended, from qualified practitioners only, to all frontline ASC staff. The training is delivered by Norfolk Police, with two sessions available each month.

16.5.9. Professional curiosity has been highlighted to all staff by internal communications, and through the Norfolk Safeguarding Adult Board.

16.5.10. A procedure has been developed which highlights the requirement for a manager to be consulted before a case with outstanding risk is considered for closure. There is also a clear process which requires the AP to report their findings to the SAPCs for further decision-making and next steps. This has made decision-making safer.

16.5.11. Exception reports have been developed which identify cases where safeguarding concerns were initially raised, and when further information was gathered there was no need for a S.42 enquiry to proceed. From these cases, a dip sample is taken, which are looked at to ascertain where the team managers agree with the decision not to proceed to S.42 enquiry. Any issues identified feed into ongoing training.

16.5.12. During the panel's meeting with Helen's family, a question was asked about the monitoring of communications, to ensure that procedures and practices described above are adhered to. The ASC panel member clarified with team managers after the meeting that calls into the CSC are recorded and recordings are retained for a period of six months; a sample of these calls are assessed by Quality Assurance Officers and Team Leaders.

16.5.13. During the interview with the IMR author, the AP commented that a great deal of information needs to be shared with ASC staff and that it is easy to miss important pieces of information. The AP therefore suggested the development of safeguarding "cribsheets" which cover questions that APs need to ask gather information in various situations, this would be updated once a year in line with changes to policy and practice.

16.5.14. The Connecting Communities programme in SCCE will remodel the front door service to address high pressure and high volume.

16.6. <u>Routine Enquiry</u>

16.6.1. As detailed above in 16.2 victims and survivors of domestic abuse want to be asked about the abuse. Practitioners, and especially those in health settings, are perfectly placed to ask about abuse as part of a routine enquiry. This does not rely on subjective "professional curiosity" and becomes embedded in standard practice.

16.6.2. As detailed within the analysis of Helen's involvement with CUH and Primary Care, there had been little or no follow up with Helen when she either failed to attend appointments, failed to book routine vaccines and screenings, pick up medication or order repeat prescriptions. The reason given for this was a lack of safeguarding concerns – no issues of risk of harm had been raised, and therefore her sudden lack of engagement was not followed up. Due to there being no known concerns for Helen's welfare, there was no policy requirement for a follow up, which will be discussed in 16.7. However, Helen had not been asked about abuse, or any other risks of harm.

16.6.3. It is problematic to rely upon a policy of only following up on disengagement when concerns have been raised, when the onus is placed upon the patient – who may have care and support needs – to disclose concerns unprompted.

16.6.4. Helen had told people about the Perpetrator's behaviours. If she was asked about this by professionals, she may not have disclosed the financial abuse and control which she had disclosed to her friend Jill and raised with her nephew. However, had she been asked every time she was seen by a medical professional it may have prompted her to either disclose at some point, or it may have planted a seed to seek help elsewhere.

16.6.5. In 2008 Public Health Scotland included routine enquiry in their Gender Based Violence Action Plan,[59] and reiterated this, as a workstream, in the 2017 Equally Safe Delivery Plan.[60] Routine enquiry involves asking all women at assessment about abuse, regardless of indicators of suspected abuse. It is in place for mental health, sexual health, health visiting, substance misuse and maternity services.

16.6.6. NHS Boards in Scotland provide ongoing routine enquiry training for new and existing staff, and their guidance requires all frontline staff to be trained in the approach before being put into practice. It is unrealistic to expect all frontline staff to be experts in responding to disclosures of abuse, however by implementing routine enquiry staff can:

- Provide a supportive environment to help disclosures.
- Gather information on the health problems associated with the abuse.
- Provide information, signposting, and referrals to specialist support where appropriate.
- Document disclosures of abuse in the patient's case file.

16.6.7. Helen's case highlights how the use of routine enquiry could have encouraged her to disclose the Perpetrators behaviours, which may have led to a referral into specialist services who could advise Helen regarding the financial abuse.

[59] CEL 41 (2008) - Gender-based violence action plan (scot.nhs.uk)
[60] Equally safe: delivery plan - gov.scot (www.gov.scot)

A disclosure of abuse could have also triggered a more proactive response to her sudden disengagement with health services.

16.6.8. Norfolk and Waveney's newly created Integrated Care Board are ideally placed to encourage providers to adopt and develop processes whereby routine enquiry becomes embedded in practice.

16.7. Proactive Follow Up

16.7.1. Prior to 12th December 2018, when she failed to attend her neurology appointment at CUH, Helen was consistent with her attendances at routine appointments, and procedures. Although, as confirmed by the Huntington's Disease Association, it is quite common for people with Huntington's Disease to fail to attend their appointments, or be sporadic with their engagement, non-attendance was out of character for Helen.

16.7.2. When Helen failed to attend the neurology appointment in December 2018, a voicemail was left for her, and a further appointment sent for March 2019. When she failed to attend this appointment, no further follow up was made. There is currently no mechanism in place at CUH for proactive follow up when a patient fails to attend.

16.7.3. When Helen failed to book a medication review with her GP in February 2019, there was no attempt made to follow this up with her. In July 2021, the Practice ran a computer search to identify patients who had not reordered their medication – Helen's name appeared on this search. As a result of this, a decision was made to stop further issue of her medication. No other action was taken.

16.7.4. Both CUH and Practice A were following their policies and procedures, which did not require a proactive follow up with Helen. As discussed above, there had been no concerns recorded on Helen's records with her GP or her neurologist, and she had not been flagged as vulnerable on her GP records.

16.7.5. Health care settings should be encouraged to develop policies which require a proactive response to sudden non-attendance, and/or sudden failure to order/collect mediation. Ideally this should be regardless of identified vulnerabilities or concerns raised – however realistically this may not be possible due to high caseloads, and therefore the required processes identified above, of routine enquiry and extension of vulnerability categories, are vital.

16.7.6. Another situation where health and social care services need to act proactively is following when concerns are raised by third parties. As has been discussed above, ASC processes have been developed, and training has been improved in light of the Care Act's inclusion of domestic abuse as a category of abuse in adult safeguarding. However, it remains imperative that all services learn lessons from this review, in terms of how to respond to concerns of domestic abuse being raised by a third party.

16.7.7. When concerns are raised by someone other than the potential victim, proactive communication in the form of information gathering is vital. This should begin with holding a safe conversation with the potential victim, away from the alleged perpetrator and where possible in person, especially if the victim has care and support needs.

16.7.8. Where a patient has suddenly disengaged from health and care services, and/or has failed to collect or order repeat prescriptions - professionals should attempt to gather information from known sources to build a picture of the potential victim's situation.

16.7.9. For example, in Helen's case, when it became apparent that she was no longer requesting her medication, the GP Practice could have contacted Helen's neurologist to determine whether she had been attending her appointments with CUH. Similarly, when Helen had failed to attend two appointments, and had not been contactable via telephone, CUH personnel could have contacted Helen's GP to determine whether she had recently been seen by her GP.

16.7.10. The learning from this review should be shared with all health and social care services in the form of an accessible case study tool. This would remind staff of the importance of proactivity in situations such as Helen's.

16.7.11. Health and social care services should be encouraged to develop their Did Not Attend policies to include the concept of "was not brought", and to include a proactive approach to assessing the welfare of patients who suddenly disengage, and/or fail to collect or order repeat medication.

16.7.12. The strategy meeting held after Helen's disappearance became apparent, enabled a coordinated discussion, and information sharing, which led to the Police launching a murder investigation. For Helen, this information sharing forum came far too late, however the impact of bringing agencies together to share what they each know should be acknowledged.

16.8. Financial Abuse Awareness

16.8.1. Financial abuse as a form of coercive and controlling behaviour[61] is often invisible in plain sight.

16.8.2. Financial abuse involves a perpetrator using/misusing money which limits and controls their partner's current/future actions, and freedom of choice. Manipulation of money is one of the most prominent forms of coercive control, depriving women of the material means for escape. With no access to

[61] Financial and economic abuse - Women's Aid (womensaid.org.uk)

independent income, they have little choice but to remain in the relationship despite the threats and risks of harm.[62]

16.8.3. As described above at 16.4, Norfolk have introduced a role within ASC with the specific remit of supporting adults with care and support needs, who are faced with financial issues. This is good practice, and the availability of this resource should be shared with frontline practitioners throughout health and social care.

16.8.4. Practitioners throughout health and social care services should be required to attend specialist financial abuse training, to assist with the identification of this form of coercive control, and to ensure an up-to-date knowledge of services available to those affected.

16.8.5. The availability of the Financial Abuse and Safeguarding Officer role should be shared with agencies and services. This will encourage and empower staff to ask questions about financial abuse.

16.8.6. The impact of the Financial Abuse and Safeguarding Officer role should be shared nationally.

17. Recommendations

Cambridge University Hospitals NHS Foundation Trust

1. Creation of a standalone Missed Appointments Policy/Process for adult patients, which includes guidance for specialist clinics for when a patient does not attend successive appointments.

2. The introduction of a Routine enquiry process for all patients within the Emergency Department, Assessment Units, and Outpatient Clinics.

Norfolk and Waveney Integrated Care Board

3. An in-house process introduced for Practices, for communication regarding disengaging patients in primary care by notification to the Safeguarding Lead GP for the Practice, or the responsible GP for the patient.

4. All GP practices should be encouraged to adopt a safeguarding adult policy.

5. GP practices should be encouraged to adopt a domestic abuse policy.

6. To encourage GP Practices to have a DA Champion, primary care practitioners should be made aware of the Domestic Abuse Champion role and how to access staff training.

[62] Sharp, N (2008) "What's Yours is Mine": the different forms of economic abuse and its impact on women and children experiencing domestic violence. London: Refuge

7. GP Practices to ensure that they have a process in place when patients do not respond to requests to attend for a monitoring check, related to their medication – for example a blood test or blood pressure check.

8. New patient registration forms, and annual health check forms to include a question about domestic abuse.

9. Task and finish group to be created to research feasibility of Routine Enquiry across health services.

Norfolk County Council

10. Evaluation report for the Financial Abuse and Safeguarding Officer role to be shared with the Domestic Abuse Commissioner's Domestic Homicide Review Repository to aid wider learning around financial abuse, and to be made available within the overview report (see Appendix B).

11. The provision of an anonymised case study for this review, to aid early learning around routine enquiry for all agencies.

General Recommendations

12. Learning to be shared from this review, via the Domestic Abuse Commissioner's DHR repository, in respect of DHR family engagement processes.

13. Learning to be shared from this review, via the Domestic Abuse Commissioner's DHR repository, regarding the invisibility of intimate partner carers who are claiming Carer's Allowance.

14. Once published, the learning from this review will be shared with the DWP Retirement Services Directorate and Customer Experiences Directorate, regarding the invisibility of intimate partner carers who are claiming Carer's Allowance.

	Recommendation	Scope	Action To Be Taken	Lead Agency/ Accountable Professional	Key Milestones	Target Completion Date	Outcome and Date of Completion
1.	Creation of a standalone Missed Appointments Policy/Process for adult patients, which includes guidance for specialist clinics for when a patient does not attend successive appointments.	CUH	The action will be taken to the Joint Safeguarding Committee Discussion with Named Nurse for children – to discuss merging the process with adults.	CUH adult safeguarding lead will take this action.	Committee member takes this action.	7th February 2023 December 2022	This was agreed that it will be a merged policy/process for adult/children.
2	The introduction of a pilot Routine enquiry process for all patients within the Emergency Department, Assessment Units, and Outpatient Clinics.	CUH	Deputy Chief Nurse agreement to proceed. The action will be taken to the Joint Safeguarding Committee to progress the plans. Independent Chair to provide a learning brief for the Committee.	CUH adult safeguarding lead CUH adult safeguarding lead Independent Chair	Joint Safeguarding Committee to take lead on the process.	December 2022 May 2022 April 2022	See recommendation 9 which links with this

3	An in-house process for communication regarding disengaging patients in primary care by notification to the Safeguarding Lead GP for the Practice, or the responsible GP for the patient.	GP practices within Norfolk and Waveney	Named GP for Safeguarding Adults to share anonymised case study with GP practices in Norfolk and Waveney to shared identified learning and recommendation for an in-house process to be adopted where the responsible GP is notified when a patient does not respond to repeated requests for medication review.	Norfolk and Waveney ICB/Named GP for Safeguarding Adults	Case to be written by Named GP for Safeguarding Adults/ICB Safeguarding Adult Team for inclusion in Safeguarding primary care monthly bulletin. This action to be shared at forthcoming Safeguarding leads meeting once DHR completed.	Circa. May 2024	
4	GP practices to be encouraged to adopt a policy for domestic abuse.	GP Practices within Norfolk and Waveney	A template policy has been developed by the Safeguarding Adult team for Norfolk and Waveney ICB and has been shared widely.	Safeguarding Adult Lead Nurse and Named GP for Safeguarding Adults Norfolk and Waveney ICB	Template policy has been reviewed by NIDAS, the OPCCN and by the Norfolk Local Medical Committee; and has been promoted to primary care with support of communications team at Norfolk and Waveney ICB.	June 2022	
5	GP practices to be encouraged to adopt a template policy for Safeguarding Adults	GP Practices within Norfolk and Waveney	A template policy has been developed by the Safeguarding Adult team for Norfolk and Waveney ICB and has been shared widely.	Named GP for Safeguarding Adults Norfolk and Waveney ICB	Template policy has been reviewed by safeguarding experts within the ICB, the Norfolk Local Medical Committee; and has been promoted to primary care with support of communications team at Norfolk and Waveney ICB	June 2022	.

6	Primary Care to be made aware of the domestic abuse champion role and how to access training.	GP Practices within Norfolk and Waveney	Overview of the domestic abuse champion role and signposting to domestic abuse champion training to be provided to all practices within Norfolk and Waveney	Safeguarding Adult team for Norfolk and Waveney ICB	Information to be included in the monthly joint safeguarding children and adult monthly primary care newsletter. Direct Email about the DA Champions initiative sent to all GP Practices Utilising Protected Learning Time to raise awareness of the DA Champions role	March 2023	
7	GP Practices to reflect on the learning from this review – to ensure they have a process in place when patients do not respond to requests to attend for a monitoring check, related to their medication.	GP Practices within Norfolk and Waveney	Named GP for Safeguarding Adults to share anonymised case study with GP practices in Norfolk and Waveney to shared identified learning and recommendation for an in-house process to be adopted where the responsible GP is notified when a patient does not respond to repeated requests for medication review.	Norfolk and Waveney ICB/Named GP for Safeguarding Adults.	Case to be written by Named GP for Safeguarding Adults/ICB Safeguarding Adult Team for inclusion in Safeguarding primary care monthly bulletin. This action to be shared at forthcoming Safeguarding leads meeting once DHR completed.	Following publication	
8	New patient registration forms to include a question about domestic abuse.	GP Practices within Norfolk and Waveney	Named GP for Safeguarding Adults will raise this at a safeguarding leads meeting	Norfolk and Waveney ICB/Named GP for Safeguarding Adults.	Safeguarding leads would take this in their own practices	April 2023	

9	Home Office and DA Commissioner Office to be made aware of the need for a national routine enquiry review and/or guidance for ICBs nationally.	NCCSP	This review to be flagged as a case study for the need for routine enquiry throughout health and social care settings.	Independent Chair and NCCSP lead	To assist with national guidance and learning around the need for routine enquiry	June 2023	
10	Impact report for the Financial Abuse and Safeguarding Officer role to be created and shared with the Domestic Abuse Commissioner's Domestic Homicide Review Repository to aid wider learning around financial abuse. A briefing paper regarding the Financial Abuse and Safeguarding Officer role to be made available within this overview report for reference.	Norfolk County Council	Impact report to be sent to DHR repository upon publication of the report. Briefing paper created. Briefing paper included within the Appendix for this report	Finance and Commercial Services Team	To assist with national guidance and learning around the impact of a Financial Abuse and Safeguarding Officer role, both on local authority finances and on the welfare of vulnerable people.	Following publication March 2023 Following publication	
11	An anonymised case study to be developed for use within training for all agencies, highlighting the need for routine enquiry and providing early learning ahead of publication of the report (see Appendix C).	Independent Chair	Case study to be developed. Case study to be distributed to Norfolk County Council providers. Case study to be available for use by all agencies.	Independent Chair	To highlight the need for routine enquiry but using the anonymised circumstances of this review to aid with training.	March 2023 March 2023 March 2023 within Norfolk Following publication nationally (available as an Appendix	

						to the report).	
12	Once published, the learning from the review around family engagement with DHRs will be shared with the Home Office/National DHR Repository.	NCCSP/Independent Chair	Upon publication, the Independent Chair will prepare a reflective analysis of engaging the family within the process, and this will be shared with the Home Office and DA Commissioner DHR Repository.	NCCSP/Independent Chair	To contribute to learning around DHR processes	Following publication	
13	Once published, the learning from this review will be shared with the National DHR Repository, regarding the invisibility of intimate partner carers	NCCSP	Upon publication, the report will be shared with the DA Commissioner DHR Repository.	NCCSP	To contribute to national thematic learning	Following publication	
14	Once published, the learning from this review will be shared with the Retirement Services Directorate and the Customer Experience Directors, regarding the invisibility of carers and Carers Allowance.	NCCSP	Upon publication, the report will be shared with the DWP panel representative by NCCSP, to be shared with the Director of the Retirement Services Directorate and the Customer Experience Directorate.	NCCSP/ DWP	To contribute to DWP learning	Following publication	

Appendix A

Norfolk Domestic Homicide Review Colton

Victim – Helen Douglas

Terms of Reference

1. Background

On 21st October 2021, Helen's family contacted Norfolk Police, concerned that they hadn't seen her since July 2017.

On 30th October 2021, her partner the Perpetrator was arrested on suspicion of the murder of DD and preventing her lawful burial. He admitted killing Helen in December 2018.

In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a DHR Gold Meeting was held on 2nd December 2021. It confirmed that the criteria for a DHR have been met.

That agreement was ratified by the Chair of the Norfolk Community Safety Partnership and the Home Office were informed. In accordance with established procedure this review will be referred to as DHR Colton.

2. The Purpose of DHR Colton.

2.1 The purpose of this review is to:

i. establish what lessons are to be learned from the domestic homicide of Helen Douglas regarding the way in which local professionals and organisations work individually and together to safeguard victims.

ii. 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.

iii. apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate.

iv. work towards the prevention of future harm in the form of domestic violence and abuse, and linked to that, domestic homicide. Illuminating the past to make the future safer. The cumulative actions stemming from Domestic Homicide Review recommendations will shape services and practices in a way that will aim to reduce the risk of future homicides.

v. contribute to a better understanding of the nature of domestic violence and abuse; and

vi. highlight good practice.

3. The Focus of DHR Colton

3.1 This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Helen Douglas.

3.2 If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

3.3 If domestic abuse was identified, this review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols, and procedures in existence at the time. If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

4. DHR Methodology

4.1 Independent Management Reviews (IMRs) must be submitted using the templates current at the time of completion.

4.2 This review will be based on IMRs provided by the agencies that were notified of, or had contact with Helen in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g., alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Helen, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

4.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR must include all information held about Helen and the Perpetrator from 1st July 2015 to 31st October 2021. If any information relating to Helen as the victim(s), or the Perpetrator being a perpetrator, or vice versa, of domestic abuse before 1st July 2015 comes to light, that should also be included in the IMR.

4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Helen and/or the Perpetrator. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2010, X was cautioned for an offence of shoplifting).

4.6 Any issues relevant to equality, i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation must be identified. If none are relevant, a statement to the effect that these have been considered must be included.

4.7 When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel, and an overview report will then be drafted by the Chair of the panel. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Norfolk CSP.

5. Specific Issues to be Addressed

5.1 Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

i. Were practitioners sensitive to the needs of Helen and the Perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

iii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Helen and the Perpetrator?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. How accessible were the services to Helen?

viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate? Was this information recorded and shared where appropriate?

ix. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

xi. Were senior managers or other agencies and professionals involved at the appropriate points?

xii. Are there ways of working effectively that could be passed on to other organisations or individuals?

xiii. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Helen, and promote their welfare, or the way it identified, assessed and managed the risks posed by Perpetrator?

xiv. Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?

Appendix B

Norfolk County Council

Financial Abuse and Safeguarding Officer Impact Report

Background

Norfolk County Council established a Financial Abuse and Safeguarding Officer (FASO) in 2019, the role:

- enables a universal service to be offered to all individuals in need of care and support, who have suffered or are at risk of financial abuse.
- is a point of contact for financial services, social services and the police in financial abuse and safeguarding cases.
- can assist in investigations and complaints of financial abuse and complete Mental Capacity assessments.
- provides guidance on financial abuse cases and complete internal training sessions.

The FASO receives cases from either the financial services departments or from social services and reviews all relevant financial and social services systems, before deciding what action is required. This can include:

- contact with the persons who have been managing the finances to request information and explanations.
- visiting the client to assess their mental capacity, their knowledge and wishes in relation to any finances concerns.
- completion of Safeguarding reports to the police, social services, the Office of the Public Guardian, and the Department of Work and Pensions.

The FASO role requires specific skills including investigative, communication, negotiation and due diligence. The NCC FASO is an ex-Police Detective which ensures the appropriate gravitas and experience in questioning and process.

Case Studies

Case Study 1 - Fraud offences committed by Power of Attorney £40,902.
Suspect taken to court suspended sentence 16 months. Power of Attorney paid back £40,902 and NCC social care debt paid in full.
Case Study 2 - Power of Attorney had not made any payments towards care challenging the financial assessment. An in-person visit was conducted and when asked to account for a historic pension income he was not able to explain. Following the visit he had found £3,000 cash in a safe, another few thousand in another bank account. All monies were then accounted for. The debt of £35,373.58 was paid and

£515.80 instalments started.

Case Study 3 - During enquiries by the FASO the Power of Attorney admitted fraud. A Safeguarding referral was sent to the police. The police investigated and charged the Attorney with fraud. He pleaded guilty and was given a community order and compensation payment of nearly £18,000. CFAT now manage the account and monthly instalments of £456.40 are being made.

Appendix C

Routine enquiry case study

Ms A was killed by her partner of thirty years. She had been living with a degenerative, life limiting condition for just over ten years, which had progressively made her more reliant on others. She required ongoing medication to reduce the impact of symptoms. Her condition bought her into contact with health professionals on a regular basis, as she attended specialist clinics and she regularly saw her GP for medication reviews. The clinic and the GP practice had good communication regarding outcomes of assessments and changes to prescriptions.

Ms A's partner was her main carer, although apart from the DWP who paid him Carer's Allowance, he is not formally recorded as her carer on any other systems. Ms A relied upon her partner for transport as her condition meant she no longer drove, and over the years her partner slowly isolated her from family.

Eighteen months before she was killed, Ms A told her family that her partner was spending her money, and she wanted to end the relationship. Adult Social Care called her, but she stated she was fine. This was a missed opportunity to engage more fully with Ms A, and to explore the allegations raised by her nephew about financial and possible emotional abuse.

Ms A described her partner's behaviours to her best friend, who at the time was not aware of coercive control and did not want to preach to her friend through fear that she would stop opening up about the issues.

Ms A was trying to tell people about her experiences of her partner's behaviour – but she never disclosed this directly to professionals.

Despite regular attendance at specialist clinics and her GP practice, Ms A was never asked whether she felt safe at home. Her partner was never asked about his role in her care.

Had Ms A been asked about her relationship with her partner, by any of the health professionals she saw regularly, she may have raised concerns about his misspending of her money – just as she had eighteen months before her death. She may have disclosed her increased isolation from her family, or her partners controlling behaviour – just as she had told her friend over coffee.

Ms A's partner was invisible yet pivotal to her health and wellbeing. Had his caring status been formally identified, he may have been offered a carer's assessment, which may have identified the need for formal carers whose presence would reduce

Ms A’s isolation – whilst also giving her another outlet to share concerns about the relationship.

Reflective questions:

How confident do you feel asking someone if they feel safe at home – and what help to you need from your employers to build this confidence?

Would you know what to do if someone disclosed that they were not feeling safe at home?

Do you know how to access the information you would need to feel confident in referring or signposting someone to specialist services if they disclose that they don’t feel safe at home?

How can you embed a routine enquiry process into your day-to-day work?

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Amanda Murr
Head of Community Safety
and Violence Reduction Coordination Team
OPCC for Norfolk
Jubilee House
Falconers Chase
Wymondham
NR18 0WW

8th February 2024

Dear Amanda,

Thank you for resubmitting the report (Helen) for Norfolk Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in January 2024.

The QA Panel felt there was positive engagement with Helen's family which gives Helen a voice. The report gives insight into her life prior to moving in with the perpetrator and the way in which the progression of Huntington's disease impacted her ability to care for herself.

The QA Panel felt the review identifies a number of missed opportunities by agencies and surfaces some fundamental elements of domestic abuse in the context of intimate partner caring. It was clear how disability can impact a person's vulnerability to domestic abuse.

The QA Panel noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home

Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel