BEXLEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Executive Summary of the report into the manslaughter of Linda[1]

In September 2020

Independent Chair and Author of Report: Paula Harding

Associate of Standing Together Against Domestic Abuse

[1] pseudonym

Contents

Executive Summary

1. Background

1.1. This summary outlines the process undertaken by Bexley Community Safety Partnership in reviewing the circumstances leading to the manslaughter of a sixty-six-year-old woman, who was resident in their area. It considers the nature of agencies' responses in the year before she was killed by her husband.

1.2. In order to protect the anonymity of the victim and her family, the following pseudonyms have been used:

Designation	Relationship to victim	Age at the time of the homicides
Linda	Victim	66
David	Husband and perpetrator of the manslaughte	68

1.3. Criminal proceedings were completed in June 2021.The perpetrator was convicted of the manslaughter of his wife and sentenced to a Hospital Order requiring him to be detained in a secure mental health facility under section 37 of the Mental Health Act 1983 and a Restriction Order under section 41 of the Mental Health Act 1983, to be detained without limit of time.

2. Review Process

2.1. The decision to undertake a domestic homicide review was made by the Chair of Bexley Community Safety Partnership, after consultation with partner agencies. A summary of the review process is featured in Appendix A; the review panel members are listed in Appendix B; the key lines of enquiry are featured in Appendix C and agencies participating in this review are featured in Appendix D, as well as those who had no contact. The Overview Report was endorsed by Bexley Community Safety Partnership before being submitted to the Home Office for approval.

2.2. The Independent Chair of the review wishes to thank everyone who contributed their time, patience and co-operation to this review.

3. Summary of Chronology

3.1. LINDA was aged 66 at the time of her homicide and was enjoying retirement from her career in the financial sector. Her husband, DAVID, was aged 68 and had not yet retired. He was very successful professionally, with a senior role in a large telecommunications company and was described as a 'workaholic'.

3.2. The couple had been married for 43 years and had no children. They lived in a large, detached, gated house and enjoyed a financially comfortable lifestyle. Friends, family and neighbours were interviewed for the criminal investigation, and all described the relationship as stable and caring. It was not until 2019 that a change in DAVID's behaviour was observed by the couple's friends and family, and he began to erroneously believe that his wife was having an extra-marital affair.

3.3. DAVID's mood deteriorated during the national lockdown, which had been implemented by the government to manage the Coronavirus pandemic in March 2020. During this time his morbid jealousy and paranoid beliefs grew. He believed that, as well as having an affair, that his wife was poisoning him and trying to kill him for financial gain.

3.4. In July 2020, he was seen at the Urgent Care Centre where he disclosed various ailments and stress from work and relationship difficulties. He went on to consult his GP about unintentional weight loss and was referred for rapid investigation of cancer. He also referred himself to MIND, again disclosing anxiety and his beliefs about his wife's affair.

3.5. In August 2020, DAVID assaulted the handyman, with whom he believed his wife was having the affair, causing him a minor injury. He also smashed a window and proceeded to chase his wife and the handyman brandishing a crowbar, before fleeing the scene. He was treated as a missing person and shortly later taken into custody for common assault, where he was assessed by a doctor and psychiatric liaison nurse. He was deemed to have mental capacity and whilst not acutely unwell, had anxiety and depression with the possibility of early cognitive decline.

3.6. LINDA was seen by specialist safeguarding police officers. A domestic abuse risk assessment was undertaken with her, and she was assessed as facing standard risk. She disclosed various forms of domestic abuse from her husband: his unsubstantiated jealousy; he restrained her by her wrists and arms; he confiscated her car keys, money and bank cards. She declined referrals to domestic abuse services but was given their details. However, she did not want her husband to return home.

3.7. Both LINDA and the handyman declined to provide statements, to the police, recognising DAVID's mental ill-health, and in the absence of other evidence, and at Linda's request, no further criminal action was taken. DAVID agreed to stay in a hotel, where he stayed for the next five weeks.

3.8. During this period, DAVID attended various health agencies, repeating his allegations of being poisoned and he had increasing paranoid delusions. He consistently declined mental health assessments until the end of August when he was assessed by the Mental Health Team as being extremely anxious with a likely development of dementia. The Team considered him to be at a low risk of harm to himself or others, and he was due to be allocated a care co-ordinator at the next multi-disciplinary team meeting to be held a week later. However, in the meantime, LINDA had reluctantly let her husband back into the family home and, on the following day, he killed her.

4. Key Findings

4.1 The couple had little contact with agencies, but it was reassuring to see, in the only incident reported to the police, that a domestic abuse risk assessment was undertaken, and she was offered a referral to domestic abuse services.

4.2 However, there were missed opportunities to explore economic abuse when it was known that the perpetrator had confiscated her bank cards, money and car keys preventing her from leaving and isolating her from the assistance of family and friends at a time when isolation was exacerbated by the Covid pandemic.

Learning Point: **Economic Abuse**

Practitioners need to be curious about the extent of economic abuse and its impact upon the victim, as a form of coercive control. A household's relative affluence could mask the fact that a victim's access to economic resources may nonetheless be restricted or controlled.

4.3 One month before the homicide, the perpetrator was required to leave home and stay in a hotel. Although he was allowed to return home on the day before the homicide, this separation was seen as a key factor in the homicide.

Learning Point: Separation and domestic abuse

Separation should be treated as a time of heightened risk. Nearly half of all women who are killed through domestic abuse were separating or trying to separate from their abusers. Victims need to be made aware of those risks when they are making plans to separate, and rigorous safety planning and safety measures should be put in place at those times.

4.4 In health settings, there were missed opportunities to enquire about domestic abuse when LINDA presented with injuries and vague symptoms before this time. There were also missed opportunities to consider DAVID's concerns about being poisoned, prior to establishing that these stemmed from his paranoid delusions.

Learning Point: Routine enquiry in health settings

Health practitioners are trusted professionals and will often be the first or only point of contact for domestic abuse victims seeking support (Home Office, 2021). Appropriate and sensitive routine enquiry should be standard practice across all front-line health and social care services that women with experience of abuse come in to contact with, in line with NICE Quality Standards (QS116, 2016) and Making Every Contact Count[2] (Public Health England, NHS England & Health Education England, 2016).

4.5 Whilst health agencies in Bexley incorporated routine training on domestic abuse in line with national expectations, the panel recognised that the current national expectations of domestic abuse being covered within safeguarding training risked diluting the crucial elements of understanding the dynamics of coercive control. Health practitioners recognised that as domestic abuse training was not mandated in NHS contracts, it was

[2] https://www.england.nhs.uk/wp-content/uploads/2016/04/making-every-contact-count.pdf

challenging to be able to organise bespoke training and release staff from their roles to undertake the training necessary to build their core competencies in domestic abuse. A recommendation has been made on this point.

4.6 However, the panel recognised the commitment of Bexley Community Safety Partnership to adopting the Pathfinder Toolkit (2020) which aims to improve the capacity of health professionals to respond to domestic abuse. In addition, it recognised the Partnership's introduction of a multi-agency Domestic Abuse Champions Network which, at the time of writing, has recruited 200 professionals across the statutory and voluntary sector, offering support and signposting on domestic abuse to other professionals.

4.7 The panel recognised that abuse amongst older generations can be minimised or ignored and reflected that the older ages of the couple may have led to missed opportunities to enquire about domestic abuse

Learning Point: Domestic Abuse and Older Women. A 'generational invisibility' and a 'generational silence.'

Practitioners need to be aware that domestic abuse occurs across the age span and that older women face additional barriers to understanding their experiences as domestic abuse and in accessing help including:

- Less likely to identify their experiences as domestic abuse
- Likely to have lived with abuse for prolonged periods before getting help
- Lack awareness of support services and less likely to want to discuss personal matters with professionals
- Face isolation and fear disrupting family dynamics
- More likely to suffer from health problems, reduced mobility or other disabilities which can exacerbate their vulnerability to harm

4.7.1 Little attention appeared to have been given by health agencies, in the few attendances of which they were aware, to the potential risk to LINDA arising from her husband's deteriorating mental health and increasingly paranoid beliefs about being poisoned by her. Agencies, beyond the GP, did not appear to consider LINDA's emerging caring responsibilities.

Learning Point: Paranoid Delusional Beliefs and Risk to Others

Practitioners always need to be alert to the risk to partners, family members and carers where an individual's mental health is deteriorating, and paranoid delusional beliefs about them are emerging.

Learning Point: Carers

Practitioners need to be alert to the value of a carer's assessment where an opportunity to discuss a carers own needs and concerns as well as caring responsibilities could take place. In the context of domestic abuse, the opportunity for an informed carer's assessment could be vital.

4.8 Although the review was unable to engage DAVID's employer in this review, there is a growing awareness of the role of employers in addressing domestic abuse. This has been made all the greater as the Covid pandemic has, in many cases, blurred the lines between home and the workplace. At the time of writing, Statutory Guidance for the Domestic Abuse Act 2021 remains in draft form (Home Office, 2021). However, the guidance draws attention to the duty of care that employers have in being able to identify and respond to domestic abuse within its workforce and their role in raising awareness of domestic abuse and signposting those affected to support.

5. Recommendations

Recommendation 1: **Economic Abuse**

Bexley Community Safety Partnership should promote professional awareness of economic abuse as a method of coercive control within domestic abuse, together with the fact that economic abuse can happen irrespective of income and wealth. They should seek assurance from its partner agencies that they have enacted the new definition of economic abuse within their policies and practice.

Recommendation 2: **Separation and domestic abuse**

Bexley Community Safety Partnership should promote the risks associated with separation in domestic abuse. They should seek assurance from partner agencies that victims are being made aware of those risks and ensuring safety planning and safety measures are being undertaken to mitigate those risks.

Recommendation 3: **Routine enquiry in health settings**

Bexley Domestic Abuse Health Sub-Group should seek assurance from health agencies that routine or targeted enquiry into domestic abuse is standard practice across all front-line health services in line with NICE Quality Standard 116 and is accompanied by robust pathways into specialist services.

Recommendation 4: Domestic Abuse Training in Health

The Home Office considers liaison with the Department of Health and Social Care and the Royal Colleges to provide a framework defining the level of domestic abuse education, awareness, competence correlating to job roles in health and social care, together with the domestic abuse training requirements for those roles.

Recommendation 5: Domestic Abuse and Older Women

Bexley Community Safety Partnership should continue to raise awareness with agencies and the public that domestic abuse occurs across the age span. The Partnership should seek assurance that partner agencies are working to effectively address the barriers that older women face, including challenging prejudice and stereotypes that restrict the options available to them.

Recommendation 6: Employers Role in Responding to Domestic Abuse

That the Chair of Bexley Community Safety Partnership seeks assurance from the perpetrator's employer that it is aware of incoming expectations of employers to identify and respond to domestic abuse within its workforce and raise awareness of domestic abuse and the services that are available for those affected.

Recommendation 7: Employers Role in Responding to Domestic Homicide Review

That the Home Office considers strengthening the expectations of private sector employers to engage with domestic homicide reviews.

Recommendation 8: Monitoring Outcomes from the Review

Bexley Community Safety Partnership to provide feedback to the bereaved family in 6 months' time concerning the impact of the recommendations made, and actions undertaken, in this review.

Single Agency Recommendations

BMI Blackheath

- Include routine questions on personal safety and domestic concerns on all assessment paperwork (applying to multiple hospitals)
- All clinical staff complete Safeguarding Vulnerable Adults 3
- All Consultants to complete Safeguarding Vulnerable Adults 3
- IMR to be presented anonymously at local Clinical Governance Meeting and at Regional Safeguarding Meeting

Hurley Group (NHS Partnership)

- To undertaking a review of adult safeguarding and domestic abuse policies and procedures, to include:
    - The introduction of policy and procedures on routine/targeted enquiry where indicators of domestic abuse are present
    - The introduction of a system prompt if a patient has attended with a previous injury
    - The introduction of a standalone domestic abuse policy
    - The relationship between mental health and domestic abuse to be included in both safeguarding and domestic abuse policies
    - A mandatory question on mental capacity to be added to the clinical assessment of all adult presentations to the unit
    - Documentation of domestic abuse in the clinical notes accompanied by quarterly audit of compliance

Lewisham & Greenwich NHS Trust

- Develop separate bespoke clinical policies for domestic abuse and for supporting staff experiencing domestic abuse

- Provide specialist standalone domestic abuse training at Level 3 in addition to that which is already provided under Level 3 adult safeguarding training
- Raise awareness of male victims of domestic abuse
- Audit triage questions to ensure routine enquiry on domestic abuse
- Consider the need for referrals to GP for follow-up of mental health concerns through safeguarding assurance
- Consider recording of mental capacity and risk at safeguarding assurance

Metropolitan Police

- Officers in charge and their supervisors in this case should be reminded of their responsibilities under the Vulnerable Adult assessment Framework (VAF) and the criteria for Adult Come to Notice (ACN) Merlin reports.
- Officers in charge and their supervisors in this case should be reminded that reports should be updated within a timely fashion and of secondary risk assessment responsibilities.

Oxleas NHS Foundation Trust

- The Trust's Clinical risk assessment and management policy should be adhered to. This would include a detailed formulation of the presenting risk
- Consideration of domestic abuse within the initial assessment and information on local domestic abuse services to be provided to service users
- Ensure the team have access to Domestic Abuse training, including the 15 Domestic Abuse High Risk Indicators.
- Following initial assessments team members should discuss the outcome with a senior colleague to confirm the risks and plans

The General Practice

- To develop a standalone domestic abuse policy and provide procedures, advice and training for the practice concerning:
- How to use routine enquiry to invite disclosure and raise concerns of domestic abuse
- How to safely enter information into patient's individual notes including the use of the "confidential tab" in the medical records so it would not be visible online access and to ensure it is omitted from disclosure if insurance companies or others ask for a release of medical records, when it would be inappropriate (containing third party information) or potentially dangerous if disclosed
- Introduce "pop up alerts" to case notes enabling future contact to alert another doctor to potential issues
- Training for staff regarding indicators of domestic abuse including allegations of poisoning
- Training for staff on how to address the risk posed to others by a patient's declining mental health
- Implement the use of Solace Lanyards for practice staff
- Raise awareness of domestic abuse amongst older people
- Introduce the role of domestic abuse champion into the Practice

Appendix A: The Review Process

Summary

The decision to undertake a domestic homicide review was made by the Chair of Bexley Community Safety Partnership, and the Home Office was notified of the decision in October 2020. An independent chair and review panel were appointed, and the review was managed in accordance with the relevant statutory guidance.

The review panel members are listed below and included representation from Solace Women's Aid who deliver domestic abuse services in the area. They provided particular expertise on gender, domestic abuse and the broader 'victim's perspective' to the panel. The panel members were all independent of the particular case. Likewise, beyond this review, the independent chair had no connection to Bexley Community Safety Partnership or its agencies.

The process began with an initial meeting of the review panel in March 2021 but was delayed thereafter by criminal proceedings which concluded in June 2021. Terms of reference were drawn up and incorporated key lines of enquiry as featured below. Agencies participating in this review are featured below as well as those who had no contact.

The review panel met on four occasions and the Independent Chair met with the victims' family a number of times. Family members contributed to the terms of reference and considered the draft Overview Report and their comments have been incorporated.

The Overview Report was endorsed by Bexley Community Safety Partnership Partnership in before being submitted to the Home Office for approval.

Appendix B: Review Panel Members

Name	Designation	Organisation
Paula Harding	Independent Chair	Associate of Standing Together Against Domestic Abuse
Dean Morris	Director of Clinical Services	Black Heath Hospital, BMI Healthcare
Deborah Simpson	Domestic Abuse and Sexual Violence Strategy Manager	Bexley Community Safety Partnership
Jacqui Lansley	Head of Housing	Bexley Housing Services
Jennifer Cirone	Deputy Director	Solace Women's Aid
Jennifer Liddington	Named GP for Safeguarding, Bexley	South-East London Clinical Commissioning Group
Julie Carpenter	Safeguarding Officer	London Ambulance Service
Klara Sonska	Team Manager, Pier Road Project, Bexley Addictions	South London and Maudsley NHS Foundation Trust
Louise West	MARAC Coordinator	Bexley Community Safety Team
Mala Karusa	Safeguarding Adults Lead at	Guy's and St. Thomas' NHS Foundation Trust
Malcolm Bainsfair	Head of Safeguarding Adults & Principal Social Worker	Bexley Adult Social Care
Matt Beavis	Detective Sergeant, Specialist Crime Review Group	Metropolitan Police Service
Michael Fullerton	Lead Nurse for Safeguarding Adults	Guys & St Thomas' NHS Foundation Trust
Kadiatu Fofanah	Adult Safeguarding Advisor	Lewisham and Greenwich NHS Trust
Philippa Uren	Designated Nurse for Adult Safeguarding	South-East London (Bexley) Clinical Commissioning Group
Samantha Iriving	IAPT service lead	MIND Bexley
Sharon Fernandez	Deputy Medical Director, Unscheduled Care	The Hurley Group
Stacy Washington	Safeguarding Adult Lead	Oxleas NHS Foundation Trust
Sue Govier	Named Nurse Safeguarding Children	Dartford and Gravesham NHS Trust

Appendix C: Key Lines of Enquiry

The review focussed on the year before the homicide, as the perpetrator's mental illness and abusive behaviour were reported to have commenced within this time. However, health agencies were required to analyse their involvement outside of this timeframe with particular regard to any injuries or indicators of domestic abuse that may have been presented in recent years.

In addition to the generic issues set out in statutory guidance (Home Office, 2016), the review focussed on the following specific key lines of enquiry:

i. To analyse how the needs of LINDA and DAVID were identified by agencies and how they responded, taking into account issues of equality and vulnerability. To include

- assessment of agency's response to LINDA's degenerative illness
- assessment of agency's response to DAVID's mental health and mental capacity and actions that considerations given where DAVID declined engagement with services and assessments

ii. To analyse the opportunities for agencies to identify and assess risks through domestic abuse. If domestic abuse was not known, analyse opportunities for routine or selective enquiry.

iii. To identify and assess opportunities to enable the victim to engage with specialist domestic abuse agencies

iv. To analyse how agencies worked together to meet the needs and risks faced by LINDA and DAVID.

v. To consider the impact of arrangements over Coronavirus upon agency responses and upon LINDA and DAVID.

vi. To consider how well equipped were staff in responding to the needs, threat or risk identified for the couple. Were staff supported to respond to issues of domestic abuse, safeguarding and public protection through

- Robust policies and procedures
- Strong management and supervision
- Thorough training in the issues and opportunities for personal development
- Having sufficient resources of people and time

vii. To consider how public awareness around domestic abuse has been raised in the area amongst older people and disabled people.

Appendix D: Agency Involvement

Individual agency reports and chronologies were provided to the review by:

- Guys & St Thomas' NHS Foundation Trust
- Lewisham and Greenwich NHS Trust
- London Ambulance Service
- Metropolitan Police
- MIND
- Oxleas NHS Foundation Trust
- The GP Practice
- The Blackheath Hospital
- The Hurley Group NHS Partnership

The following agencies were contacted but confirmed that the individuals had not been known to them or that their contact was not relevant to this review:

- Bexley Drug and Alcohol Services
- Bexley MARAC
- Bexley Women's Aid
- Dartford and Gravesham NHS Trust
- King's College Hospital NHS Foundation Trust
- London Borough of Bexley: Adult Social Care, Children's Social Care, Education and Housing Services
- Solace Women's Aid
- South London and Maudsley NHS Foundation Trust
- The Probation Service[3]
- Victim Support

[3] At the time the Probation Service was divided into the National Probation Service and Community Rehabilitation Company and neither had contact with the individuals concerned