Domestic Violence Homicide Review

Overview Report

Death of Anne

Aged 70

Died: May 2021

Report completed July 2023

Independent Panel Chair: Robin Jarman LL.B, MSt (Cantab)

Section One – Introduction

1. Introduction

1.1 This review concerns Anne, who, in May 2021, was fatally stabbed by her son Ron. The names of the deceased, the perpetrator and other members of the family mentioned in this review are pseudonyms chosen by Anne's daughter. At the time of her death Anne was 70 years of age and Ron was 36 years of age.

1.2 In 2008, following the natural death of Anne's partner Tom, both Anne and Ron continued to share the family bungalow. In 2013, Ron became a full-time carer for his mother. A role and responsibility which became increasingly onerous as Anne's health deteriorated.

1.3 As part of any review it is important to gain an understanding of the character and personality of the victim and the perpetrator involved. The author and panel members are grateful to Anne's daughter, Tracey, who has kindly provided relevant insight.

1.4 Anne was born in Blackpool, Lancashire. She had in total seven children, four of whom were from her first marriage and who reside in Scotland. They had no contact with their mother for many years. Her other three children are from her relationship with Tom, with whom she was not married, but had taken his name. In 2017, following a series of bitter disputes Anne became estranged from her other youngest son David and thereafter had no further contact. Her daughter Tracey, lives in a neighbouring county and had limited contact with her mother and brother Ron.

1.5 Anne had also been married to two Egyptian nationals whom she met whilst on holiday. Anne had frequently travelled to Egypt but never remained for more than a few weeks at a time, her primary residence remaining in the UK. There

are no reported children from either of these marriages. She was formally divorced from her second Egyptian husband in September 2012.

1.6 Anne did not really have any hobbies, she enjoyed window shopping, rummaging around charity shops and attending the local Bingo. However, this all stopped as her health deteriorated, thereafter, she spent a lot of time watching television. Anne is described by Tracey as 'having no filter' and frequently being blunt and to the point. Tracey also states that she had a difficult relationship with her mother who was very controlling. She left home at the age of sixteen and had little contact with her mother thereafter.

1.7 At the time of her death Anne was frail, used a mobility scooter to get around and spent most of her latter days in bed. Her health had deteriorated over the preceding fourteen months she had lost significant body weight (4St 10lb) and although it was ascertained that she had cancer, this had gone undiagnosed and was only discovered at the post-mortem. She was type 2 diabetic, which was controlled by diet and medication. Anne was of good character and had no criminal convictions.

1.8 In 2008, following the death of his father, Ron continued to live with his mother. He had minimal contact with his other two siblings, and he had no contact with his half-siblings in Scotland.

1.9 Although he had previously been a football coach, he no longer worked. He eventually became a carer for Anne and from May 2013 was in receipt of a carers allowance, although, according to Tracey, his income and finances were reportedly managed and controlled by his mother.

1.10 Although physically well, Ron suffered from asthma and whilst never formally diagnosed, was understood to have experienced learning difficulties during childhood. According to Tracey, Ron has a son from a former relationship, however, Anne would not allow the child to live at their address. The baby was adopted at birth and Ron had no further involvement or contact with the mother or child.

1.11 Ron rarely ventured away from the home, other than shopping with Anne and occasionally attending local football matches as a spectator. He played soccer with some football club members once a week, although this had stopped during the Covid restrictions, but had recently resumed. He had last played soccer the week before the death of Anne where other players had described him as being withdrawn and he stated that he was feeling low. One of his footballing associates felt that his mother was a strong controlling influence on

him and that he had no real friendships and that this had been the case for a number of years.

1.12 Neighbours had noticed that Ron and Anne were affected by the Covid pandemic, Tracey recalls that her mother had significant concerns about contracting covid, during a telephone call around August 2020 her mother stated she would not go outside as she was petrified of contracting covid. Ron was seen frequently cleaning and disinfecting the house, both outside and inside. He insisted on washing his and his mother's clothes when they returned from shopping. Ron was described by his neighbours as being a quiet individual who would communicate openly when engaged, he was amiable, and his mother appeared to be the centre of his life.

1.13 In the days leading up to the tragic events, from the available evidence and his actions it is clear that Ron was struggling with maintaining the level of care required by his mother. He eventually reached out for help and support from both charitable and statutory organisations and was also in frequent contact with his sister, Tracey, who to that point, other than occasional messages and telephone contact, had had no face-to-face contact with him or her mother for nearly 3 years.

1.14 Ron had no record of convictions prior to the homicide.

2. Timescales for Completion

2.1 The primary purpose of Domestic Homicide Reviews is to prevent domestic violence and homicide and improve service responses for victims by developing a co-ordinated multi-agency approach to ensure that abuse is identified and responded to effectively at the earliest opportunity. This report was commissioned by the Fenland Community Safety Partnership (FCSP). This statutory partnership brings together several agencies with the aim of reducing crime, disorder, and anti-social behaviour across the Fenland area of the County of Cambridgeshire.

2.2 The homicide was referred by the police to the Fenland Community Safety Partnership (FCSP) and also to HM Coroner. The Home Office were notified by the partnership within seven days of the tragic incident.

2.3 The chair of the FCSP determined that a domestic violence homicide review was necessary in accordance with the 2016 Home Office statutory guidance for multi-agency domestic homicide reviews. Statutory agencies were duly notified of the requirement to identify and secure relevant material.

2.4 In June 2021, the first appointed Independent Chair, Mr Steve Appleton, wrote to all relevant agencies seeking initial scoping information and nomination of panel members. Unfortunately, for personal reasons, Mr Appleton was unable to continue in this role which understandably caused some delay and eventually led to a second Independent Chair and author, Mr Robin Jarman, being appointed.

2.5 The DHR panel met on five occasions, at the beginning of each meeting a picture of the deceased was shared with all panel members.

- At the first meeting held on 14th October 2021, it was revealed by the police, that the defendant had now been deemed fit to stand trial, with a likely trial date set in early 2022. Given the circumstances, at the request of the police Senior Investigating Officer, with a view to ensuring the prosecution case was not in any way compromised, the review process was placed on hold.
- At the second meeting held on 29th March 2022 the panel members were informed that earlier that month, Ron had been found guilty of Murder and sentenced to life imprisonment with a minimum custodial sentence of 11 years. Relevant police prosecution papers were requested.
- At the third meeting held on the 11th August 2022, the panel members were able to discuss and consider information provided by the police investigation. Individual Management Reviews (IMRs) were requested from the Police, Adult Social Care and Health with a reviewed timeline to commence from January 2019.
- At the fourth meeting held on the 15th December 2022, the completed IMRs were discussed in depth, lessons learnt identified and recommendations considered.
- At the fifth meeting held on the 6th of February 2023 the contents of the draft report were shared and reviewed accordingly. A detailed discussion over the proposed recommendations occurred.

3. Confidentiality

3.1 The findings of this review are confidential. Information is available only to participating officers/professionals, their line managers and the respective agencies commissioning professionals. The report has included pseudonyms where necessary to protect the identity of the individual(s) involved, selected by Tracey in consultation with the author.

3.2 The review is owned by the Fenland Community Safety Partnership.

4. Terms of reference

The following terms of reference were agreed by the panel and subject of continuing review during the process. Tracey was afforded the opportunity to read through and agreed with the terms proposed by the panel.

1.Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.

2.Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence.

3.Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.

4.Apply these lessons to service responses including changes to policies and procedures as appropriate; and

5.Prevent domestic violence homicide and improve service responses for all domestic violence victims through improved intra and inter-agency working.

6.Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life.

7.To identify the best method for obtaining and analysing relevant information, and over what period prior to the homicide to understand the most important issues to address in this review and ensure the learning from this specific homicide and surrounding circumstances are understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified.

8.To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion.

9.To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel. Any parallel investigations to be identified.

10.To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required.

11.To identify whether the victims or perpetrator were subject to a Multi Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings.

12.To determine whether this case meets the criteria for an Adult Case Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were 'an adult with care and support needs'

13.To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it.

14.To identify how the review should take account of previous lessons learned in Fenland Community Safety Partnership and from relevant agencies and professionals working in other Local Authority areas.

15.To identify how people in Fenland Community Safety Partnership area gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague.

16.To identify how people in Fenland Community Safety Partnership gain access to advice and assistance for elderly care and support services and to identify any opportunities for improvement.

17.To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations.

Further Panel considerations

18.Could improvement in any of the following have led to a different outcome for Anne, considering:

a) Communication and information sharing between services with regard to the safeguarding of adults.
b) Communication within services
c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

19.Whether the work undertaken by services in this case are consistent with each organisation's:

a) Professional standards
b) Domestic abuse policy, procedures, and protocols

20.The response of the relevant agencies to any referrals from 1st January 2019 relating to Anne and Ron. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with Anne and Ron**.**
b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
d) The quality of any risk assessments undertaken by each agency in respect of Anne and Ron**.**

21.Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

22.Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic, and religious identity of the respective individuals and whether any

specialist needs on the part of the subjects were explored, shared appropriately and recorded.

23.Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

24.Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

25.Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

5. Methodology

5.1 This overview report has been produced with the support of completed IMRs prepared by authors from the key agencies involved in this case and other relevant agency information. Each IMR author is independent of the victim and family of the victim, and of management responsibility for practitioners and professionals, whom have been involved in this case.

5.2 The overview author has also fulfilled a dual role and has chaired the panel meetings in respect of this domestic violence homicide review process. This is recognised as good practice and has ensured a continuity of guidance and context for the review. There have been a number of useful professional discussions arising and the panel meetings have been referenced and minutes taken appropriately for transparency. The author has made himself available for contact by professionals involved in this review throughout the duration of the review process.

5.3 In support of the information received from agencies, from the outset of this review process, the author has sought to engage with the family. Unfortunately, due to the estranged family dynamics, only Tracey, the daughter, has participated. The author informed her of the availability of the Advocacy After Fatal Domestic Abuse charitable support service (AAFDA). She declined the invitation to attend the panel meeting on the 6th February 2023 but in advance, read through the draft report. She provided written feedback to the author, clarifying a few factual points and indicated that she was content with our findings and proposed recommendations.

5.4 It is important to clarify that this review is not about who is culpable, but how we learn to prevent such tragic events in the future.

6. Involvement of family, friends, work colleagues and community

6.1 Since 2017, owing to arguments and reported domestic incidents between Anne and her youngest son David he became estranged from his mother and his two siblings. He was living in the North of England at the time of the homicide and has not spoken to either his mother, Ron or sister since mid-2017. In the past David had frequent disagreements with the family and there are several police records referencing what appears to be evidence of the poor relationship including a serious assault against his father Tom in 2004.

6.2 Tracey had moved out of her parent's home when she was aged 16, although she had briefly returned following the breakup of a relationship. Tracey has described her relationship with her mother as being difficult and she refers to her mother's "toxic" attitudes to her and other members of the family. She made infrequent contact with Ron and her mother and until early May 2021, she had had no personal physical contact with either of them at their home for nearly three years.

6.3 In terms of a community perspective both Anne and Ron were familiar to others within the neighbourhood and would pass the time of day with them. Ron would also assist others with gardening and household tasks, and he was perceived as being a caring son for his mother. They would frequently be seen out together in the town centre shopping; Anne would use a mobility scooter as her mobility was poor. Neighbours had no concern for their relationship and knew that Ron was her carer, and that he put his mother first. One close neighbour had noted Anne's significant weight loss over a relatively short period of time, assuming that this was connected to her diabetes.

6.4 Prior to the homicide, no concerns had been raised by any of their neighbours about Anne or Ron either as individuals or concerning their relationship. There had been no third-party reports of concern about them, or any incidents linked to their address concerning domestic abuse or violence between them.

7. Contributors to the review

7.1 The following agencies have contributed to the review: Each of the agency authors is independent of any involvement in the case including management or

supervisory responsibility for the practitioners involved. The review panel has extended requests to the relevant services and agencies within the other areas.

- Cambridgeshire Constabulary
- Cambridgeshire and Peterborough Integrated Care Board (formerly Clinical Commissioning Group) – on behalf of involved GP Practices
- Cambridgeshire and Peterborough Foundation Trust (CPFT)
- The Queen Elizabeth Hospital NHS Trust, Kings Lynn
- Fenland District Council Housing Services
- Cambridgeshire Domestic Abuse & Sexual Violence Partnership
- Change Grow Live Drug and Alcohol Services
- Cambridgeshire County Council Adult Social Care & Safeguarding
- Cambridgeshire and Peterborough Independent Domestic Violence Advisor (IDVA) services
- Refuge

7.2 The following individuals and agencies comprise the DVHR panel or have acted in an advisory capacity to the panel and independent chair.

Name	Agency	Role	IMR
Linda Coultrup	Integrated Care Board (formerly Clinical Commissioning Group) representing Primary Care	Named Nurse Safeguarding Adults Primary Care	IMR
Amanda Warburton	DASV Partnership	Partnership Officer	
Sarah Gove	Fenland District Council	Housing & Communities Manager	
Vickie Crompton	Cambridgeshire DASV	Partnership Manager	
David Savill	Cambridgeshire Constabulary	DA Lead	
Jenni Brain	Cambridgeshire Constabulary	Detective Chief Inspector	IMR

Richard Stott	Cambridgeshire Constabulary	Detective Inspector SIO	
Emma Foley	North West Anglian Foundation Trust (local hospitals)	Adult Safeguarding Lead	IMR
Mandy Geraghty	Refuge	Senior Operations Manager	
Alan Boughen	Fenland Community Safety Partnership	Community Safety Partnership Officer	
Rachel Robertson	Cambridgeshire & Petersfield Foundation Trust	Domestic Abuse Lead	

8 Panel Chair and author of the overview report

8.1 The Independent chair and overview author, Mr Robin Jarman, is provided by Sancus Solutions.

8.2 He is a retired senior police detective and former senior investigating officer. During 2001-2 as a member of Her Majesty's Inspectorate of Constabularies, he conducted a review of Homicide Investigation across Northern Ireland. He was formerly the Head of the Criminal Justice Department of Hampshire Constabulary and following his police retirement served as the first Independent Deputy Police & Crime Commissioner for Hampshire where he led on all police and justice initiatives, including the chairing of the Local Criminal Justice Board sub-group on victim related issues. In 2015 his pioneering work with Project CARA, the first domestic violence randomised controlled trial (overseen by Cambridge University) attracted a national police innovation award for the policing of domestic violence. He also possesses extensive experience in partnership working.

8.3 Mr Jarman and Sancus Solutions have no connection with the Fenland Community Safety Partnership, other than the provision of case reviews.

9. Details of any parallel reviews

9.1 No other reviews were discovered of relevant note.

10. Equality and diversity

10.1 Both Anne and Ron were white British and had resided in England since birth.

10.2 The author is satisfied that the IMR authors and the DHR Panel have addressed, where appropriate the protected characteristics under the Equality Act 2010 and in accordance with the terms of reference. Specific comment is made accordingly within the report narrative where appropriate in respect of those characteristics which are,

• Age • Disability • Gender reassignment • Marriage and civil partnership • Pregnancy and maternity • Race • Religion or belief • Sex • Sexual orientation

This report highlights Anne's disability and potential vulnerability, she was frail and had to use a mobility scooter to get around, she was also, at the time of her death unable to weight bare.

10.3 Ron, although described as having learning difficulties, was not statemented, or diagnosed with any disability or mental health conditions. The panel considered how this aspect may have affected his ability to access to relevant services.

10.4 When considering the circumstance of Anne's death, it is more usual for females to be killed by male partners. Of the 270 female victims of domestic homicide from March 2016 to March 2018, the suspect was male in 260 cases (96%). (ONS, 2019)

10.5 Recent research has also highlighted increasing evidence discussing homicide of older adults killed by a family member (for example, Benbow et al, 2018). Benbow et al (2018) have highlighted the conflation between adult family violence, intimate partner violence (IPV) and elder abuse. However, studies consistently show that Adult Family Homicide (AFH) is gendered (Holt 2017; Bows, 2019), with the most common form of AFH being parricide. Existing international research suggests that perpetrators are more likely to be the son or grandson of the victim who is usually female (Cussen and Bryant, 2015; Sharp Jeffs and Kelly, 2016, Montique 2020). This review supports these findings.

10.6 In addition, Bracewell et al (2021) who conducted a review of related DVHRs found that characteristics of victims and perpetrators victim information presented more than half of victims were women (n=37; 56.1%) and nearly all perpetrators were men (n=60; 90.9%). Victims were aged 17 to 95, with an average age of 60.7 years (SD = 18.6). Perpetrators tended to be younger than victims (age range: 15–73 years), with an average age of 33.0 (SD = 11.6). Again, this review supports these findings.

10.7 Interestingly, Bracewell (2021) also found that financial/economic abuse of victims was reported in seven DHRs but noted that there were no instances whereby the victim was described as financially abusing the perpetrator. This review identifies the existence of potential economic abuse by the victim on the perpetrator, however, it is not known if this abuse materially influenced the homicide.

10.8 Further recent and salient research has been undertaken by The Domestic Homicide Project (the Project), based in the Vulnerability Knowledge and Practice Programme (VKPP), which was established by the National Police Chiefs' Council and the College of Policing. The Project was created in May 2020 through Home Office funding to collect, review, and share quick-time learning from all police-recorded domestic homicides and suspected suicides of individuals with a known history of domestic abuse victimisation.

10.9 Between 1st April 2020 and 31st March 2022, the Project recorded a total of 470 domestic-abuse related deaths. Of these, 79 victims (17%, over one in six) were either cared-for by the suspect or were the carer of the suspect.

10.10 A few relevant key-points were identified: Cases involving a caring relationship increased overall from Year 1 to Year 2 as we emerged from the pandemic (by 39%); but this comprised a dual picture in which AFH deaths increased but IPH deaths decreased. It is possible that Covid-related restrictions put intimate partner cared-for victims at more risk, whereas emergence from the pandemic exposed victims of familial domestic abuse to more risk – especially where the suspect was cared-for by the victim.

10.11 Of the 79 victims with carer relationships, nearly three quarters (73%, n = 58) of victims were female and one quarter (27%, n = 21) were male. Victims of adult family homicides (AFH) tended to be older than victims in other case types, with 79% (n = 26) aged 55 and over compared with 67% (n = 20) for Intimate Partner Homicides (IPH) (Figure 2). This finding is also consistently supported by prior research (Bows and Davies, 2019; Holt, 2017).

10.12 Finally, their research found that AFH victims tended to be older than intimate partner homicide victims. Conversely, AFH suspects tended to be younger than IPH suspects. This is in keeping with the profile of AFH which often involved (adult) children or grandchildren killing older relatives.

11. Dissemination

11.1 A copy of the report will be disseminated to all agencies identified as being involved in the case, as listed in section 7, for consideration of their involvement and appropriate reflection and action. The report will also be shared with the Cambridgeshire Police and Crime Commissioner as well as the Cambridgeshire Domestic Abuse Sexual Violence Partnership. An anonymised version of the report will be published on the Fenland Community Safety webpage which can found on the website of Fenland District Council.

12. Background

12.1 Anne and Ron rarely ventured out and had little by way of a social life. During 2020/21 Anne's health gradually deteriorated, her caring needs increased, and Ron was struggling to cope. In the days leading up to the tragic event Ron tried to put a care plan in place, contacting several companies, and he later told social services he was depressed and had concerns over the costs involved with the provision of private care.

12.2 On Friday the 7th May 2021, during a telephone call Ron was asked by a practitioner of adult social services if he could manage a few more days while they put a care package in place. There was no indication of any immediate risks or emergency. An appointment was scheduled to commence arrangements on Monday 10th May.

12.2 On the 7th May Ron accompanied his mother to her GP surgery for a routine diabetic review appointment where she was seen by a nurse who noted she was frail but there were no other issues of concern recorded on the medical notes.

12.3 The following day Ron became tearful whilst out food shopping, he informed a shop assistant that he had to do everything but that nothing was good enough. Later that same day he broke down again during a visit from his sister. She noticed that the house was clean, but her mother was now "skin and bone" and had lost a lot of weight.

12.4 The next evening Anne was fatally stabbed in the chest by Ron at their home address. Ron immediately contacted the police and confessed. He was subsequently convicted of Murder.

13. Chronology Police

13.1 There are a number of historical events concerning the wider family, some of which date back to 2004. The more recent relevant occurrences are summarily:

13.2 In April 2017 Ron reported an incident at their home between David and his mother. David was threatening his mother and had been told to leave the house two days previously due to his attitude and his abuse of alcohol. Although he had originally left of his own accord, he had returned and was making veiled threats of harm to his mother and was refusing to leave. Officers attended and David willingly left with the officers. There were no offences identified. Officers completed a DASH risk assessment which identified Anne, as being of a standard risk, no referrals concerning the incident, or the DASH risk assessment were made known to other agencies. The DASH referral does not identify Ron by name but acknowledges his presence within the household. He is not identified as a victim of the abuse.

13.3 Thereafter, during 2017, further incidents involving David, Anne and Ron are reported to the police. They reveal the strained and deteriorating relationship between David and his Mum which ultimately ended with him removing his personal belongings from the bungalow under police supervision. A few months later a further incident occurred which led Anne to state on the formal police record *"I want nothing to do with him, and neither does Ron."*

13.4 Further to the above and in support of their aforementioned anxiety over Covid, in 2021, during lockdown periods, Ron and Anne separately reported two incidents to the police indicating that a neighbour was breaching Covid-19 regulations by frequently allowing visitors to the address. However, no formal action was taken by the police.

13.5 Other than several reports to the police made by Ron in 2018 and 2019 concerning vehicles parked and obstructing the footpath and presenting a danger to his mother in having to negotiate around the parked vehicle, there were no other calls concerning Anne or Ron or their address to the police or any third-party reporting until the tragic events unfolded.

Key sequence of events to the homicide

13.6 Between the 2nd May 2021 and the 7th May 2021, Ron made a total of 56 telephone calls to various agencies. A number of telephone calls and visits were also made to him and Anne by those agencies in response to his communications. A list of the fifteen agencies and organisations contacted by Ron during that period follows;

- Age UK	- Anglia Care
- Bluebird Care Agency	- Hopeline UK
- Cambs Pet foundation Trust	- Caring Together
- Corden Care	- Fenland District Council
- Clarion Housing	- Carers UK
- Carers Support Team	- Local Doctors
- Cambridgeshire County Council Social Care (Fenland District)	- Helping Hands
- Pure Heart Home Care	

The following summary describes the salient events.

13.7 On the 3rd May 2021 (a Bank Holiday) two telephone calls were made by Ron to Age UK, national advice line. The calls are recorded by the service. The service provided details of their locally based service and information on seeking care support via e-mail to Ron, advising that as it was a bank holiday, he may get limited or no response.

13.8 On the 3rd May he contacted Hopeline UK, a suicide prevention charity.

13.9 On the 4th May 2021, Ron contacted Cambridgeshire County Council Adult Social Care (Adult Early Help team) seeking advice concerning care for his mother. A referral was made by Adult Services for further enquiry by practitioners to take place for a carers assessment and he was advised of that fact accordingly.

13.10 On the 4th May Ron contacted the administration team at the Cambridgeshire and Peterborough Foundation Trust (CPFT) requesting a

continence assessment for his mother. A referral was made to the CPFT Continence Team to contact him for an assessment.

13.11 On the 5th May 2021, Ron contacted Cambridgeshire County Council Adult Social Care stating he was aware that a referral for an assessment for his mother had been made but he was seeking more urgent support and care and was concerned about finances and payment. Adult Social Care returned a call to him the same day, but with no response from Ron.

13.12 On the 5th May 2021, Ron contacted Bluebird Care, a private care-provider requesting care support for Anne. Bluebird Care confirmed to Ron that they would attend and assess Anne's needs the following day.

13.13 On the 5th May, Ron contacted Anglian Care Ltd, which provides private care services. His call was recorded and responded to by a care manager later that day where the level of care and cost was discussed. An appointment for assessment was made for the following day. Later that day, Ron contacted the company and left a message cancelling the appointment for the 6th May as it clashed with a medical appointment arranged for his mother.

13.14 On the 5th May, Ron made numerous calls to Corder Care, a private care company.

13.15 On the 6th May 2021, Cambridgeshire County Council Adult Social Care contacted Ron by phone, arranging for a carers assessment to take place on Monday 10th May at their home.

13.16 On the 6th May 2021, A Bluebird Care representative visited Anne and Ron at their home, assessed Anne's needs and a contract for care services was agreed between them and Bluebird Care for two visits per day each week with immediate effect.

13.17 On the 6th May 2021, Anne had an appointment booked to see a healthcare professional at her GP surgery, which she attended, and no concerns were raised by the examining healthcare professional.

13.18 On the 6th May 2021, Ron contacted Clarion Housing requesting a delegated authority form which would enable him to speak to them on behalf of Anne.

13.19 On the 7th May 2021, Bluebird Care commenced services with a morning visit to Anne. Later that day, Ron cancelled the contract by telephone. This was the only care visit to Anne made by the company.

13.20 On the 7th May 2021, Cambridgeshire County Council Adult Social Care contacted Anne and Ron by phone. Anne consented for Ron to act on her behalf. He was advised that if he could manage for a further week that the reablement team would possibly be able to assist with Anne's care. Ron was concerned about payment for care and was advised by the practitioner that he could cancel the private contract with Bluebird Care as they were within the 14-day notice period.

13.21 On the 7th May 2021, a female employee from Cambridgeshire County Council Adult Services contacted Ron to enquire about his welfare as he appeared anxious in previous telephone contact with her. He informed her that he had cancelled the Bluebird Care contract. It was agreed that he would speak to adult services again on Monday 10th May.

13.22 On the 7th May 2021, Ron took his mother to her GP surgery for a routine diabetic review appointment where she was seen by a general practise nurse who noted she was frail but there were no other apparent health issues. He accompanied his mother during the appointment and mentioned that she was suffering from incontinence and that he had already requested an incontinence assessment for Anne.

13.23 On the 9th May 2021, Ron contacted the Cambridgeshire County Council Emergency Duty Team enquiring about a power of attorney and he was advised to call back the following day when somebody would be able to give him appropriate general advice.

14. Relevant events involving other members of the family:

14.1 On the 8th May Ron contacted his sister Tracey by telephone seeking help and in consequence she decided to visit them that same day. When she arrived, she was met by Ron who immediately broke down in tears saying that everything was too much, and he was unable to cope.

14.2 This was also the first time that Tracey had seen her mother for almost 3 years and she observed her mother's significant weight loss and deterioration of her health over that time. She also noted Ron's apparent anxiety, primarily concerning how he was needing support for the care for his mother. As mentioned, Tracey had not had a good relationship with her mother, in fact she described their relationship as being "toxic", inferring that it was her mother's domineering behaviour and control, that led to her leaving home at 16, with only occasional visits to the home to see her father until he passed away in 2018.

14.3 Tracey accompanied Ron shopping in Peterborough on the 8th May where they purchased items for both him and their mother. Tracey noted that Ron had no means to pay for the items purchased. He informed Tracey that Anne controlled all of the household finances. Tracey states she paid for the items of shopping and that when they returned to the bungalow that her mother said she would reimburse her for the purchases by a bank transfer. Tracey also states that her mother had also controlled the finances in her relationship with Tom, which had caused issues in their relationship.

14.4 Tracey returned with Ron to their bungalow later that afternoon and spoke briefly to her mother, who was sitting up in her bed. Her mother stated to Tracey that she was not going to go into care although Tracey made it clear that this may need to happen in the future should her health deteriorate further. She states that Ron was present during this conversation and that she "had to carefully navigate the conversation explaining that care wasn't what they both feared, that it was respite for them both, after this they appeared to be calmer around the subject".

14.5 On the morning of 9th May, Tracey spoke to Ron briefly on the telephone. She later sent a series of text messages concerning arranging a Power of Attorney for their mother. Ron did not appear to understand what this involved, although Tracey explained this proposal to him and that she would take on that responsibility. She had also advised Ron to tidy the house of clutter before social services visited, which was scheduled for the 10th May 2021. She had no concerns over the cleanliness with their bungalow.

The homicide investigation:

14.6 Following his arrest and an initial referral for medical treatment, Ron was discharged from hospital and taken into police custody, where his fitness to be detained was assessed. Due to his mental health at the time, he was assessed as being unfit for detention and interview. Therefore, he was not formally interviewed by the police.

14.7 During a police search of the bungalow, in his bedroom a laptop displaying an internet search read: "*If slit someone's throat how long in prison*". The laptop was digitally forensically examined and, in the days leading up to the murder, open-source internet searches were made in the early hours of the morning.

Those searches included: "*how long can you get for murder with knife*" and "*if I stab and slit someone's throat how long do I go jail for*". Other searches included the words: "*mum murdered", "mum murdered by son with knife"* and *"son murdered mum with knife*". There were also searches relating to domiciliary care and care agencies in the locality. Ron had also run similar internet searches in what was a very short timeframe before he committed the murder. One such search narrative was, *"If mother and son live together and mum goes into care home, can he stay at the home".*

14.8 Further investigation revealed that during April 2021, Ron had made searches relating to counselling, help with mental health and depression, and the Samaritans. From early May 2021, there were regular searches made relating to care providers.

14.9 A note, written by Ron, was subsequently found at his home address by Tracey and handed to the police. He expressed his feelings of hopelessness and lack of support during the covid pandemic and appears to be referencing his neighbours breaking the covid regulations. In the note he mentions his mother's health going downhill and not being able to cope with it.

Medical Chronology Ron

14.10 References had been made to the fact that Ron suffered from learning difficulties. Medical Records indicate that he had 1-2-1 support whilst at school but achieved eight GCSEs, later attending night school for Maths and English. A further note dated May 1994 also referenced 'Learning Difficulties' as a coded

entry in his medical notes but nothing else is mentioned about an educational statement.

14.11 Ron was an asthmatic which was managed with two different inhalers one to prevent symptoms and one to alleviate the tight chest and wheezing associated with asthma. His asthma was controlled during this period, excluding one attendance to the GP surgery in November 2020.

14.12 In 2021, it was documented, and coded in his medical notes, using the national SNOMED code that Ron was a carer. SNOMED codes offer unique codes to a variety of common phrases, conditions, concerns etc that allow GP surgeries to run reports, for example on all carers within the practice, or all asthmatics. This is good practice, as this alert could identify him as requiring support in his caring role, as carer stress and carer fatigue is a recognised phenomenon. However, there was no information to suggest there was any professional curiosity regarding who he was caring for, although his mother was also a patient at the practice, and it is possible the dynamics of this relationship were already known as there is evidence of links in their records previously, between mother and son. To clarify, the occupants of the household are routinely recorded and linked by the IT system.

14.13 There is no mention in the medical notes of any history or referral for mental health or depression concerns.

Anne

14.14 The medical records of Anne were explored as part of this review. The key issues are highlighted as follows.

14.15 For several years Anne was prescribed oral medication to alleviate inflammatory polyarthritis, she also suffered from diabetes.

14.16 In September 2019 as part of an annual diabetic review her body weight is documented as 14St 2lb.

14.17 In November 2020, at her next annual diabetic review her weight is recorded as 9st 6lb, a loss of 4stone 10lbs. The records do not state whether this was intentional weight loss, however, her diabetes management plan in 2015 identified weight loss as recommended and had been monitored since that time. The weight loss probably resulted in her blood sugar level returning to a normal reading. During this visit it was also recorded that Anne reported suffering from cracked ribs since March 2020. Unfortunately, the cause of the cracked ribs is not

documented and there is no evidence of any appointment elsewhere regarding the cracked rib statement. Tracey has since informed the author of this report that she believes her mother tripped in the garden causing the cracked ribs.

14.18 On the 4th May 2021 an incontinence assessment is documented as required. An administrative entry on her notes report 'son and carer', requesting continence support.

14.19 On the 7th May 2021 Anne attended the surgery with Ron for a diabetic 6 month review. Medical notes recorded that Anne was not eating as much, was unable to stand and weight-bear, so she was not weighed. Unfortunately, the reason for not being able to weight-bear is not explored. Notes indicate that it was also reported Occupational Therapy were involved. Blood sugar change was noted as normal and no action required. However, subsequent blood test results were identified as abnormal. It was identified that she was anaemic. Action was taken to identify the cause by referring to a specialist for further investigation.

14.20 During the post mortem the examining pathologist observed widespread metastatic cancer with a solid mass in the right breast, likely the primary source. This resulted in a heavy tumour burden. Despite the severity of natural disease, it was not relevant to the cause of death in this case.

Adult Social Care Chronology

14.21 On the 6th May 2021 Ron contacted Adult Social Care to ask for an assessment for his mother, he explained her basic needs and said he was feeling depressed due to his caring role. He confirmed he had recently sourced a private package of care. When spoken with on the telephone Anne agreed for the assessment to be undertaken.

14.22 Ron was advised that he could access services from Cambridgeshire County Council (CCC) and this would be initially free of charge, with the aim of supporting Anne to become as independent as possible. He was concerned about the expense of the private care he had arranged and was advised by the practitioner to cancel that arrangement. He was informed that the CCC services could start within a couple of days if he was able to continue to support in the interim.

14.23 Ron was also offered an Occupational Therapy assessment for his mother, he was concerned about this but reassured and agreed. Ron was advised to contact the GP again for his mother due to Ron expressing that his mother had lost so much weight and slept all the time. Ron was asked to contact CCC again

if the GP would not agree to a consultation. During the call Ron expressed concern that his mother would be taken away hence his reluctance to contact Adult Social Care however he was reassured this was not the case.

14.24 A carers assessment was arranged for the 10th May 2021. The records indicate that it was later confirmed with Ron that he had arranged a new GP appointment for the following week.

14.25 Analysis of relevant records has found that adult social care identified early on the need for carers support, which was planned to take place within 3 working days. The practitioner who took the referral provided Ron with relevant advice and guidance in regards to his mother and the concerns that Ron raised.

14.26 On the 7th May Ron called the Emergency Duty Team (out of hours) when he again expressed being concerned about the financial implications of care support. It was recorded that he appeared anxious on the call but confirmed it was not an emergency and agreed for a call back later. A request was passed internally for a call back to discuss during working hours.

Caring Together

14.27 During the police investigation it was established that between the 3rdand 5th May Ron had also contacted Caring Together on numerous occasions. Caring Together is a charity supporting carers of all ages across Cambridgeshire, Peterborough and Norfolk. They are commissioned by Cambridgeshire County Council to provide a number of services to adult carers across Cambridgeshire and Peterborough including information and advice, emergency planning etc, and are designed to reduce or delay onward referral to adult services They receive between 700-800 calls per month to the helpline.

14.28 On the 4th May a message left on their telephone system by Ron led to an advisor calling him and talking through the emergency plan process. The advisor did not consider the call unusual and had no cause for concern. An emergency plan form was sent in the post to Ron that same day.

14.29 On the 11th May a completed emergency plan form was received by Caring Together, signed by Ron and dated 8th May.

15. Overview & Analysis Accessing Support

15.1 It was only established after the tragic events, that Ron had made repetitive contact with a number of care providers, charities and other agencies in the days leading up to the homicide. During that period, there had been no calls for service to the address made to the police and at no stage had Ron intimated any threat or risk to his mother in his contact with the respective agencies and care providers. Indeed, the opposite can be inferred, in that he appeared, albeit with some anxiety, to have wanted to seek as much care and support for her with appropriate professional advice. There were no referrals made to the police from other agencies concerning contact with Ron or Anne.

15.2 Notwithstanding the above a possible concern was the potential challenges that may be faced by Ron with navigating the local pathway of support services. Ron is understood to have learning difficulties as a child and there is an inference from his communications with agencies and care providers that he did not fully understand the processes involved in arranging assessments for Anne and the timeframes that these were likely to take. However, following detailed assessment, in the opinion of the author, Ron was able to successfully identify and access the relevant services reasonably quickly. Importantly, the responses by those agencies to his requests also appear to be timely and Ron's concerns had been heard. He was offered appropriate advice and support. Adult Social Care Services were due to attend the address the morning of the homicide.

15.3 It is noted that the lack of a power of attorney arrangement concerning Anne was identified by the sister during her visit on the 8th May, but the timing of this came only hours before the tragic events. Ron does not appear to have been able to comprehend what this involved, and this may have compounded his concerns.

15.4 It is clear that Ron was struggling to cope and needed help. This is further evidenced during his interaction with local supermarket store staff on Saturday 8th May 2021, when he stated in response to the concern for his welfare as he was emotional and visibly upset, *"I'm struggling, Mums getting worse, and I don't know what to do*". When asked if he could get any help he responded, *"No, I'm doing everything, but nothing is good enough, it's really hard"*. The inference was that Ron was not only finding accessing support difficult, but that his mother was also possibly not content with his efforts.

Carer Role

15.5 Carers UK state that 1 in 8 people in the UK are carers (or 6.5 million people), which increased to 1 in 4 over the Covid-19 pandemic State of Caring 2021 report, Carers UK (2021).

15.6 Research conducted by Warburton-wynn (2022) identifies 'taking on a caring role for a family member is often not a planned choice. People can become unwell unexpectedly and sometimes over a longer gradual process, and societal norms suggest that we have a responsibility to care for immediate family. Long-held misconceptions about 'going into a home', alongside the costs of seeking formal support, can play a large part in people taking on a caring role whilst others may feel that it is their 'duty' to care for a parent as they were cared for as a child'.

15.7 Several of these identified issues were present in this case. Ron found himself taking on the role of carer for Anne. As her health deteriorated the caring responsibilities and duties undoubtedly increased. From May 2013 Ron was a full-time carer, in receipt of a carers allowance and living in their rented bungalow. This financial and housing dependency may have contributed to a delay in seeking external support. The conversations he held with adult social care and other organisations clearly reveal that he was anxious about seeking external help and possibly being assessed as not being able to cope. His Mum being taken into care and the costs involved as well as the subsequent potential loss of his home were genuine issues of concern.

15.8 This cocktail of complex concerns must have weighed heavily on Ron's mind whilst he continued to do his best to care for a controlling mother whose health was rapidly deteriorating. The various searches he made on his computer evidence his thinking around that period.

15.9 Ron's apprehension and anxieties are discussed in Bracewell's research (2021) 'whilst local authorities have a statutory duty to offer carers' an assessment to assess their own needs, wellbeing and desired outcomes, there are a number of reasons why these are not offered or taken up including professional failure to identify carers, carers not self-identifying and fear that such an assessment might expose them as being inadequate to provide care'.

15.10 Like many other family carers across society, Ron has assumed the role of carer and was in receipt of a carer's allowance without any form of professional assessment of his suitability for the role, capability or reflection as to his own personal needs. In addition, as Anne's health deteriorated the caring

requirements undoubtedly grew and yet there was no plan in place for this foreseeable development.

15.11 The research by Bracewell (2021) is worthy of further reflection, he found 'the carer had not received a formal assessment but performed many of the tasks of a carer. Under the Care Act 2014, a person supporting another on a regular basis is entitled to a carer's assessment which focuses on the person's needs and wellbeing (including being safe). Assessments provide the opportunity of supporting both people. In Bracewell's view the evidence available, in his research, indicates that this appears to be a missed opportunity for the prevention of homicide.

Domestic Abuse

15.12 Whilst examining the family background and key incidents in the chronology, the author has focused on examining and identifying key episodes where the relationship between the perpetrator and victim identifies or indicates a background of abuse, violence or other incidents that could infer any prevalence of domestic abuse or any potential hidden behaviours within the household, that were either directly or indirectly linked to the victim and/or the perpetrator for context. The analysis identifies concerns of controlling behaviour and financial abuse by the victim on the perpetrator, factors which also contributed to significant co-dependency.

15.13 The further comments of Warburton-wynn (2022) are worthy of reflection 'it is known that carers are at risk of controlling behaviours from the person they care for, such as being restricted on having time away, being required to report their movements and becoming socially isolated. Domestic abuse survivors often report feeling worried that no one will believe them if they speak out about what is happening. If the person exhibiting abusive behaviour has physical care needs, this could make a carer victim of abuse even less likely to hope for support. Fear of disclosure can extend to other anxieties such as disclosing to other family members as well as fears about reporting to professionals.

15.14 What does appear to be significant is that Anne was controlling of Ron, in particular his finances and that although he was her carer, he had a very limited social footprint, limited interactions with his siblings and few friendships.

15.15 Ron's lifestyle seems to have been strongly influenced, if not controlled by his mother over a sustained period to an extent that she appears to have been his primary singular focus and this perspective may have been further influenced and affected by the restrictions imposed by the Covid-19 pandemic. The

influences on him by his mother does appear to include her fiscal control of his and the household income to the extent that although he was in receipt of benefits, he seemingly had limited independent financial means.

15.16 Further to the above, it is known that during the early part of 2017, Ron was exposed to domestic abuse within the household which was perpetrated by his brother David against Anne. How this affected Ron is unreported, but there is a significant gap between those events between June 2017 and May 2021, where there are no other relevant incidents recorded by the police.

15.17 Due to his poor mental health at the time of his arrest, following medical assessment he was declared unfit to be detained or interviewed. In consequence, we do not know his precise mindset at the time of the homicide.

15.18 Consideration by the author was given towards meeting Ron in prison, however, his sister, Tracey, advised against this on the grounds that he appears to have no memory recall from day to day and becomes distraught when asked about his past.

Medical

15.18 The caring responsibility that Ron was undertaking, was not formally recorded by his GP practice until a few weeks before the incident, this raises the question whether an earlier referral for a carers assessment for Ron or a care needs assessment for Anne could have altered their pathway?

15.19 The national SNOMED system used within primary care which recorded that Ron was a carer can quickly identify all patients with carer responsibilities for example in the practice. However, there was no information to suggest there was any professional curiosity regarding who he was caring for, although his mother was also a patient at the practice, and it is possible the dynamics of this relationship were already known as there is evidence of links in their records previously, between mother and son.

Anne's Medical Notes

15.20 As identified by the Domestic Homicide Project (the Project) conducted by the national College of Policing, 'the Covid 19 pandemic seems to have made it harder for vulnerable carers and those being cared-for to access outside support and help, for both physical and mental needs and for care support'. It follows that when support is withdrawn, scarce or more difficult to access, risks increase.

15.21 It is known that Anne lost considerable weight during the pandemic period, and it was subsequently discovered during the post mortem that she was suffering from terminal breast cancer. It is also known that both Anne and Ron were anxious over contracting Covid 19. The lockdown periods may well have affected their decision making in regard to seeking GP appointments, treatment, help and support. However, she declined or ignored invitations to smear tests, mammograms and bowel screening. This, of course, is currently patient choice.

15.22 According to her medical notes the status of both her mobility and condition during the review period did not appear to have significantly progressed and her mobility remained 'limited'. However, she was unable to weight-bear at her very last appointment which challenges this recorded opinion. Her analgesia although different to 2008 was unchanged during the review period, commencing January 2019. Anne took Naproxen an anti-inflammatory and tramadol an opioid used for moderate to moderately severe pain but there was no obvious progression with these conditions from 2008.

15.23 There was however, a sudden and unexplained weight loss of 4 stone 10Ib between September 2019 and November 2020 -14 stone 2lb in September and 9 stone 6lb pounds 14 months later, having previously maintained a static weight of circa 14 stone. Whilst this weight loss is achievable if someone has been dieting, Anne was not asked about this reduction in weight and if it was intentional. An opportunity for professional curiosity was missed.

15.24 The next review was at her face-to-face diabetic appointment in May 2021. Prior to this in February 2021, her son had reported he was her carer, which was new information and he had also requested a continence assessment – a developing picture, significant weight loss which was possibly overlooked at the time but in conjunction with a request by her son for a continence assessment and the statement he was her carer, which continued to evolve during the diabetic review; Anne also stated she was less mobile due to cracked ribs (used a mobility scooter), but there was no evidence of any professional curiosity as to who or how this diagnosis was made and more importantly, how the injury occurred. Had she fallen – was an assessment required? Was it a deliberate act of violence? Elder abuse by family members could have been a factor? such questions do not appear to have been explored.

15.26 Three days after the continence assessment request, Anne attended the practice for a diabetic review with her son, but was unable to weight-bear, so her weight was not checked despite a 4 stone loss previously. Weight is routinely

checked as part of a diabetic review as there is an association between excess weight and rising/abnormal blood sugars. Diabetics are usually encouraged to reduce their body mass index to within a normal range as this best manages their blood sugar levels. Occupational Therapy support was also discussed and confirmed by Ron as in place. However, there was no reason specifically documented why she was unable to weight-bear.

16. Conclusion

16.1 The author has not identified any incident, where there was involvement by the police or other organisation before the homicide, where the risks for Anne were of any obvious concern of the threat of risk or harm or potential harm to her by Ron. Historical incidents do indicate that she appears to have been at potential risk from her other son David during the middle part of 2017 where Ron was either a witness to the events or was within the household at the time.

16.2 Following the death of his father in 2008, Ron assumed the role of carer for his mother and whilst in receipt of benefits and a carer's allowance it appears no carers assessment was undertaken. Indeed, it was only a few weeks before the homicide that GP records acknowledged his role as a carer. The opportunity to assess his and Anne's current and future needs was missed.

16.3 It is reported that Anne was a person who exercised control over family members. This included fiscal control and it is clear that Ron had little or no access to finances himself. Whether this level of economic abuse contributed to the homicide is not known. However, Ron was clearly very concerned about his mother and how best to support her, whilst also recognising his own financial and housing dependency was inextricably linked to any actions or decisions taken. Her rapid deterioration and increasing care needs undoubtedly exacerbated the situation.

16.4 Eventually, recognising he needed support, Ron, navigated his way through the local pathway of potential support. He successfully managed to do this, and appropriate advice and guidance was provided accordingly in a timely manner. The practitioners made appropriate onward referrals and discussed these with Ron. Unfortunately, the homicide occurred before a practical plan could be fully implemented.

16.5 A post mortem examination was conducted which identified widespread metastatic cancer with a solid mass in the right breast, likely the primary source. This resulted in a heavy tumour burden. The pandemic lockdown periods and associated problems with attending GP surgeries may have contributed to her

cancer being undiagnosed. However, as acknowledged by the medical profession review, there was an evident lack of professional curiosity over her significant weight loss, reported cracked ribs, being unable to weight-bear and incontinence assessment request, which could have led to an alternative pathway being taken by both Ron and Anne.

17. Lessons learned/to be considered

17.1 Medically the decline in Anne's physical health over the last 18 months of her life appears to have been missed. Professional curiosity about her living arrangements, nutritional intake and care and support arrangements were also not considered when she was seen at her diabetic reviews which occurred six monthly and evidence of decline was evident in November 2020.

17.2 A lack of professional curiosity was evident regarding exploration of the reported cracked ribs and an inability to weight-bear. She was displaying poor physical health in May 2021, unable to weight-bear, had considerable weight loss and deranged blood results, likely linked to her nutritional intake although unconfirmed and she complained of undiagnosed fractured ribs. If it had been questioned/identified how Anne had suffered the alleged cracked ribs i.e. had she fallen, she could have had a falls risk assessment, mobility assessment and referral to physiotherapy all of which are universal services. If it was a physical assault this could also have been addressed.

17.3 Ron was in receipt of a carers allowance from 2013. Unfortunately, he was never subject of a carers assessment. Recent academic research (Bracewell et al 2021) has highlighted that this may be a missed opportunity in the prevention of homicides.

17.4 A recommendation to address this issue was considered, however, in the last 12 months, domestic abuse and the needs of carers is now embedded as part of the Countywide, multi-agency Carers Strategy to ensure those who are caring for others can be identified where they may be subjected to domestic abuse.

18. Recommendations (please refer to action plan)

1 The Integrated Care Board (ICB) to publicise the findings from this DHR to all General Practices, highlighting the need for training to include:

- professional curiosity,

- the importance of documentation and the linking of 'carers' and 'cared for' on their documentation systems and use of SNOMED codes to identify carers within clinical records.
- Referrals to the local authority for Care Act assessments and carers assessments.
- Information Sharing to support staff when dealing with the lack of consent.

2 In regard to the carer, where possible, local authorities should complete the Care Act assessment/review alongside the Care Act assessment/review for the cared for. Ideally this should be considered at every contact with the cared for to ensure that the carer is appropriately supported.

3 During the next 12 months that Fenland Community Safety Partnership should work with relevant statutory partners using this case and recent national academic research to raise awareness of frontline workers of the Homicide and domestic abuse risks linked to carer's both as perpetrators and victims.

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