Domestic Violence Homicide Review

Executive Summary

Death of Anne

Aged 70

Died: May 2021

Report Completed July 2023

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

Introduction	3
Contributors to the review	4
Agencies involved	4
The review panel members	4-5
Chair and author of the review	5-6
Terms of Reference	6-9
Background Information	9-10
Summary Chronology	10
Key issues emerging	10-14
Conclusions	15
Lessons to be learnt	16
Recommendations	16-17

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, Tracey. 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 live in their rented 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. 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.

1.3 Since May 2013, Ron was in receipt of a carers allowance, although, according to his sister, his income and finances were reportedly managed and controlled by his mother. The neighbours described Ron as being a quiet amiable individual whose mother appeared to be the centre of his life. 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. His requests for support were heard and were in the process of being assessed and implemented when the homicide occurred.

1.4 Following Anne's death, it was reported and referred by the police to Fenland Community Safety Partnership (FCSP) in May 2021. The death was also referred to the HM Coroner.

1.5 The chair of the FCSP determined that a domestic 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. Contributors to the Review

2.1 This report has been compiled with the support of comprehensive Individual Management Reviews (IMRs) prepared by authors from the key agencies involved in this case and other relevant agency information, where IMRs have not been required. Each IMR author is independent of the victim, family of the victim and of management responsibility for the practitioners and professionals who have been involved in this case.

2.2 In support of the information received from agencies, from the outset of the review process, the author has sought to engage with the family. Unfortunately, due to the estranged family dynamics, only Tracey, the daughter, has participated. Tracey declined invitations to attend our formal panel meetings but spoke with the author on several occasions, read through our draft report and provided written feedback, clarifying a few factual points. She has since read the final version of the report and communicated her satisfaction with our findings and recommendations.

2.3 Agencies Involved

- 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
- Fenland 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

3 The Review Panel Members

3.1 The following individuals and agencies comprise the DVHR panel or have acted in an advisory capacity to the panel and independent chair. The panel met on five occasions and there was ongoing and effective liaison and communication between formal panel meetings.

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	

4. Author of the overview report

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

4.2 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.

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

5. Terms of reference for the review

The following terms of reference were agreed by the panel and subject of continuing review during the process.

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 analyzing 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. Background

5.1 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.

5.2 Two days before the homicide, 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 the following Monday.

5.3 On that Friday Ron also 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.

5.4 The following day (Saturday) 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. Tracey had not seen her mother or brother for a few years. She noticed that the house was clean, but her mother was now "skin and bone" and had lost a lot of weight.

5.5 The following night 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.

6 Summary Chronology

6.1 The chronology of contact and services provided is detailed for the relevant timescales between 1st January 2019 – May 2021. The police investigation identified that over the course of six days, preceding the homicide, Ron made a total of 56 telephone calls to fifteen different agencies. In response, a number of telephone calls and visits were also made to him and Anne by those agencies. The report provides relevant chronology and detailed analysis of the calls, contact and visits. In addition, a chronology of the relevant medical history for both Anne and Ron were obtained and assessed.

7 Key Issues Emerging

Accessing Support

7.1 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.

7.2 Notwithstanding the above a possible concern was the potential challenges that may be faced by Ron with navigating the local pathway of support services. 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 panel members, 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 very morning following the homicide.

7.3 Carer Role

7.4 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).

7.5 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'.

7.6 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 issues of concern.

7.7 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'.

7.8 Like many other family carers across society, Ron had 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.

7.9 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.

7.10 Domestic Abuse

7.11 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.

7.12 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.

7.13 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.

7.14 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.

7.15 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.

7.16 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.

7.17 Consideration by the author was given towards meeting Ron in prison, however, his sister, who frequently visits him, 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

7.18 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?

7.19 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 GP 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

7.20 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.

7.21 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 had declined or ignored invitations to smear tests, mammograms, and bowel screening. This, of course, is currently patient choice.

7.22 There was however, a sudden and unexplained weight loss of 4 stone 10Ib between September 2019 and November 2020, 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.

7.23 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 of 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 that he was her carer, 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.

7.24 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.

8 Conclusion

8.1 The panel review 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.

8.2 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 (from 2013) 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.

8.3 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 health deterioration and increasing care needs undoubtedly exacerbated the situation.

8.4 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.

8.5 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.

9 Lessons learned/to be considered

9.1 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.

9.2 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. It should be noted that the sister subsequently advised the panel members that Anne's cracked ribs had reportedly been sustained as a result of falling over in her own garden.

9.3 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.

9.4 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.

10. Recommendations

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.