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# Domestic Homicide Review
# Executive Summary

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

Review into the death of Barbara
in December 2019

Report Author: Christine Graham
October 2021

# Preface

Gwynedd and Anglesey Community Safety Partnership and the Domestic Homicide Review Panel wish at the outset to express their deepest sympathy to Barbara's family and friends. This review has been undertaken in order that lessons can be learnt. We wish to place on record our thanks to the family for their engagement and challenge with the Review; it has helped us form a deeper understanding of those involved and the issues they faced.

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

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

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## Section One – The review process.

1.1 This domestic homicide review was undertaken by Gwynedd and Anglesey Community Safety Partnership following the death of one its residents that occurred in December 2019.

1.2 The victim in this case will be known as Barbara. She was a woman in her 70s. She had been married to her husband for 53 years. It was her husband, who will be known for the purposes of this review as George, a man also in his 70s, who killed her on at the home they shared together on that day in December 2019. Barbara and her husband George were a couple in their 70s who had been married for 53 years. They had moved from the English Midlands to the North Wales coast in 2018 to be near their daughter. They, in fact, moved to a bungalow next door to their daughter and son-in-law, in a small cul-de-sac.

1.3 The attack that resulted in Barbara's death took place in the evening of Christmas Day. Immediately after the attack, George went round to his daughter's home and reported what had happened. The police and other emergency services were called. Barbara was deceased at the scene and George was arrested on suspicion of her murder.

1.4 In interview, George admitted the killing and was charged. He was subsequently convicted of manslaughter on the grounds of diminished responsibility. He was sentenced to 3 years 2 months imprisonment. Evidence was produced during the trial that he was subjected to years of controlling and, at times, violent behaviour from Barbara.

1.5 The Gwynedd and Anglesey Community Safety Partnership was advised of the death by North Wales Police on 27th December 2019. This was a timely notification and demonstrated a good understanding by the police of the need for a referral at the earliest opportunity.

1.6 On 31st December 2019 a discussion was held between the Community Safety Partnership Chair, Community Safety Partnership lead officer in Gwynedd Council, the Senior Investigating Officer and Detective Chief Inspector. From this discussion it was agreed that the criteria were met and that a Domestic Homicide Review would be held. The Home Office was advised of this decision the same day.

1.7 An Independent Chair and Report Author was appointed at the beginning of February 2020. The family were notified by the Gwynedd and Anglesey Community Safety Partnership that the review was to take place on 28th February.

1.8 The Independent Chair and Report Author have experience of multiple Domestic Homicide Reviews across England. Between them they have experience in criminal justice and local authority and were not previously connected in any way with the Community Safety Partnership that commissioned this review.

1.9 Agencies were asked to secure and preserve any written records that they had pertaining to the case.

1.10 The first Review Panel meeting was planned for 25th March 2020. Due to the coronavirus lockdown, it was agreed that a report would be circulated to the panel that established the review. The report set out that, following a discussion between the police SIO and the Chair, it had been agreed that the review would proceed in limited scope until the criminal justice process was completed.

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1.11 Thereafter, the following agencies contributed to the review:

- Betsi Cadwaladr University Health Board
- Cannock Chase District Council
- Gorwel Specialist Domestic Abuse Services
- Gwynedd Council
- Hywel Dda University Health Board
- National Probation Service
- North Wales Fire Service
- North Wales Police
- Staffordshire and Stoke Clinical Commissioning Group
- Staffordshire County Council

1.12 Barbara's family contributed to the review by way of personal interview, personal discussion with the Chair and Author upon receipt of a draft overview report. They responded to the overview report and as a result of their engagement a number of amendments were made.

1.13 George was contacted and invited to contribute to the review. The Chair and Report Author were able to have a telephone conversation with him from prison following his conviction.

1.14 The review panel members comprised:

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| Gary Goose | Independent Chair | |
| Christine Graham | Independent Report Author | |
| Chris Walker | Head of Adult Safeguarding | BCUHB |
| Kerry Wright | Partnerships, Community Safety & CCTV Manager | Cannock Chase District Council |
| Oliver Greatbach | Community Safety and Vulnerability Officer | Cannock Chase District Council |
| Gwyneth Williams | Manager | Gorwel Specialist Domestic Abuse Service |
| Catherine Eirlys Roberts | Senior operational officer Community Safety Partnership Gwynedd and Anglesey | Gwynedd Council |
| Mannon Emyr Trappe | Senior Manager: Adult Safeguarding, Quality Assurance and Mental Health | Gwynedd Council – Adult Social Care |
| Mandy Nichols-Davies | Head of Safeguarding | Hywel Dda University Health Board |
| Rachel Munkley | Lead VAWDASV and Safeguarding Practitioner | Hywel Dda University Health Board |
| Angharad Forshaw | Senior Probation Officer | National Probation Service |
| Gwyn Jones | Community Safety Manager for Gwynedd and Anglesey | North Wales Fire Service |
| Sara Evans | Detective Inspector | North Wales Police |
| Lisa Bates | Designated Nurse for Adult Safeguarding | Staffordshire and Stoke CCG |
| John Maddox | DHR Coordinator | Staffordshire County Council |

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1.15 It was not possible to complete the review within six months as it was not able to proceed in full scope until the criminal process was completed and COVID 19 further impacted on the progress of the review.

1.16 The Review Panel met five times and the review was concluded in October 2021.

## 1.2 Terms of Reference

**Terms of Reference for the Domestic Homicide Review into the death of Barbara**

**1 Introduction**

1.1 This Domestic Homicide Review (DHR) is commissioned by the Gwynedd and Anglesey Community Safety Partnership in response to the death of Barbara which occurred late in December 2019.

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

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

**2 Purpose of the Review**

The purpose of the review is to:

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

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

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2.3 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

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

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

## 3 The Review Process

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

3.2 This review will be cognisant of, and consult with the criminal investigation and subsequent criminal justice processes. It will be similarly cognisant of, and consult with, the process of inquest held by HM Coroner.

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

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

## 4 Scope of the Review

This review will:

4.1 Draw up a chronology of the involvement of all agencies involved in the life Barbara and the suspected perpetrator, George to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of The Act.

4.2 Produce IMRs for a time period commencing 25th December two years prior to the death and anything prior to that date that is pertinent.

4.3 Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

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

4.5 This Review will consider particularly the ages of those involved and whether this was a factor in the homicide and whether age affected the provision of service to either party.

4.6 This Review will consider the couple's move to another geographical area of the country and whether this affected their relationship, considering in particular the potential for isolation, change of established lifestyle and any other relevant factors.

4.7 This Review will consider whether there is evidence to show a trail of abuse and if so, what could be done differently to better protect others in the future.

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

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

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

## 5 Family Involvement

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

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

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

## 6 Legal advice and costs

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

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then Gwynedd and Anglesey Community Safety Partnership will be the first point of contact.

## 7 Media and communication

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

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## Section Two – Summary chronology and information learnt from the review

2.1 The victim and the perpetrator had moved to Wales to be close to their daughter who had moved there some time previously. Both were retired, ageing and it was felt by all that they and their health would be better managed if they were close to family. This was not a decision taken lightly but seems to have been one that all agreed with at the time. They had only been in Wales for around 18 months when Barbara was killed.

2.2 It is perhaps not surprising that agencies in their previous area knew much more about them both, than agencies in Wales. That said, both registered with the GP upon arrival in Wales and both had some exposure to local health services.

2.3 Barbara had experienced a number of chronic health issues which transferred to Wales upon her move. These included gynaecological problems, gastric problems, musculoskeletal problems, type 2 diabetes, recurrent migraines, essential hypertension, angina, cataracts, and a hiatus hernia, all of which she was treated for by the practice. It was, however, what her daughter saw as a cognitive decline, otherwise known as early signs of dementia or Alzheimer's that caused her family most concern. Barbara would not accept there was anything wrong, but her daughter was convinced and records show that she first underwent tests for her cognitive functioning back in 2015. None of the results met the threshold for support or treatment however, her daughter was witnessing every day events that caused her concern.

2.4 Two months before she was killed, Barbara took an overdose and was hospitalised. Initially, she was not expected to survive. She did, and several assessments were undertaken in hospital. She was subsequently discharged home with on-going support available from the community health teams.

2.5 During that stay in hospital, it was disclosed by Barbara and her daughter, at different times to different staff, that George had awoken on one occasion to find Barbara over him holding a knife to his chest and that on another occasion she had actively begun to look for petrol cans saying she was going to burn the house down. No safeguarding referrals were raised.

2.6 George was a man who also suffered a number of chronic conditions including diabetes. It also became clear during both the police investigation and this review that he masked a level of alcohol intake that was way above the norm. It was also revealed during the police investigation into Barbara's death that George had in fact been subjected to some behaviour at the hands of Barbara that caused him to fear for his safety and that he had taken some significant efforts to keep himself safe, particularly at night.

2.7 Both Barbara and George had always engaged with health services in a timely manner and were not known to other services. No prior reports of domestic abuse had been received by any agency before their move to Wales.

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## Section Three – Key issues arising from the review

3.1 The purpose of a DHR is to explore if there is evidence of a trail of domestic abuse leading up to the incident that resulted in Barbara's death. No domestic abuse was reported to any agencies by either Barbara or George, so the review has relied upon information provided by George and his daughter and that additional information that arose during the criminal proceedings.

3.2 George did not tell his daughter about what his marriage was like until they had moved to North Wales when, one day, he went into her house and cried. He told his daughter about his marriage and called his wife 'evil'. His daughter says that he is a man who was not emotional and does not show emotion, so she was not surprised that he had not talked to her before about what was happening.

3.3 There has been no evidence provided to the criminal investigation or to this review to suggest that George was domestically abusive towards Barbara prior to her killing. In his trial, the judge said that having heard the evidence, he believed that George was a decent, hardworking responsible man who had never been violent before to anyone.

3.4 Their daughter described Barbara and George's relationship as being great at times with moments of joy. Barbara's sister told the court that Barbara loved George 'to bits', and he loved her as much back. George told the court, and the review, that he still loved Barbara and that he always will. At the same time, the judge said, there were difficulties in their marriage that persisted throughout.

3.5 There is evidence that Barbara was the dominant personality in the relationship. She could be controlling and manipulative. A particular source of difficulty in the relationship was alcohol. In the past they had both drunk too much and this had led to arguments. Barbara would sometimes let George drink what he wanted but at other times she would give him an allowance. Their daughter's perception was that this was both because she cared about George and did not want him to drink himself to death but that she also did this to hurt him. The review cannot comment on this. Whist alcohol may be the source of arguments it was never the source of violence.

3.6 In considering the circumstances of this review the panel did conclude that there were concerns about whether the response to information that was made available to staff was hindered by both age and gender bias. This, coupled with a lack of professional curiosity, led to the risks that existed within the household not being identified for what they were, and information not being shared across the safeguarding network.

3.7 This review has made a total of twelve recommendations across a range of agencies that we believe will make help make the future safer for others.

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## Section Four– Lessons Identified

4.1 **BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) on behalf of the GP in North Wales**

4.1.1 Although physical needs were assessed and met there is no reference to Barbara or George' psychological wellbeing having been addressed or explored directly.

4.1.2 No verbal engagement between GP Primary Care services and MHLD services to discuss current involvement and interventions.

4.1.3 There is no record of the SaveLives Pathfinder GP practice briefing having been undertaken. This highlights the importance of undertaking the Routine Enquiry Domestic Abuse (RE DA) whereby frontline staff ask all service users about their experience of Domestic Abuse regardless of whether there are any signs of abuse. Barbara had disclosed depression and an attempted suicide was made; these are indicators to suggest that Domestic Abuse could have been discussed.

4.2 **BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) Home Treatment Team**

4.2.1 There was no consideration of routine enquiry domestic abuse during initial assessment, or upon receipt of referral following overdose from the general hospital.

4.2.2 There is no evidence of selective or routine enquire domestic abuse was carried out during the timeline.

4.2.3 There was no previous medical or psychological information known.

4.3 **HYWEL DDA UNIVERSITY HEALTH BOARD on behalf of the general hospital**

4.3.1 That individuals may raise concerns about the action being taken or their expectations and that there is a need for staff to be more curious about these concerns.

4.3.2 There is no evidence that practitioners recognised Barbara as a potential perpetrator of domestic abuse and her husband as a potential victim.

4.3.3 There was a lack of professional curiosity in establishing what action had been taken by Barbara's daughter in response to the disclosures and in establishing what she expected to the outcome to be of making those disclosures.

4.3.4 A MARF should have been submitted to the local authority to share information and enable an assessment of risks and provide a support plan as appropriate.

4.4 **GWYNEDD AND ANGLESEY COMMUNITY SAFETY PARTNERSHIP**

4.4.1 There appears to be a lack of understanding in the local community about domestic abuse – what it is and who might experience abuse.

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4.5 **WELSH GOVERNMENT**

4.5.1 The Ask and Act Training does not adequately demonstrate the prevalence and challenges with domestic abuse experienced by older people and abuse perpetrated by women.

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## Section Five – Recommendations

5.1 **BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) in relation to GP service**

5.1.1 That BCUHB ensures that the relevant legislative information on Violence Against Women Domestic Abuse Sexual Violence (VAWDASV) and the VAWDASV Service User Procedure be shared across all GP practices in North Wales

5.1.2 That BCUHB ensures training in relation to domestic abuse is available to all GP practices in North Wales, and seeks assurance from managed GP practices in relation to training compliance

5.1.3 That BCUHB reviews MDT documentation to ensure consideration for the wider engagement of services to identify a clear pathway of communication between Mental Health and Learning Disability (MHLD) services and GP practices.

5.2 **BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) – Home Treatment Team**

5.2.1 That BCUHB ensures regular quarterly audits of the clinical records in relation to key domestic abuse targets

5.2.2 That BCUHB update and facilitate Level 3 safeguarding training across MHLD services in relation to domestic abuse legislation and practice

5.2.3 That BCUHB ensures that the relevant legislative information on VAWDASV and the VAWDASV Service User Procedure be shared across all MHLD services

5.2.4 That BCUHB reviews MDT documentation to ensure consideration for the wider engagement of services to identify a clear pathway of communication between MHLD services and GP practices

5.3 **HYWEL DDA UNIVERSITY HEALTH BOARD on behalf of general hospital**

5.3.1 That the UHB holds a reflective practice session with staff exploring professional curiosity where there are concerns raised by individuals about the action taken and expectations

5.4 **GWYNEDD AND ANGLESEY COMMUNITY SAFETY PARTNERSHIP**

5.4.1 That the CSP holds a series of awareness raising campaigns in the local area. These should focus upon male victims of domestic abuse and older victims of domestic abuse. The campaigns should be targeted where they are most likely to reach these groups.

5.4.2 That the CSP reviews its current publicity arrangements in the local area to ensure that the information that is available on an ongoing basis is providing information about the different aspects of domestic abuse (ie it is not just physical abuse) and where support is provided.

5.4.3 That the CSP ensures that, as part of the publicity they are using locally, there are clear messages for family and friends of those who are experiencing domestic abuse about how they can support their loved ones.

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5.5 **WELSH GOVERNMENT**

5.5.1 That the Welsh Government reviews the content of Ask and Act training to ensure it sufficiently demonstrates the prevalence and challenges with DA and older people, and older females as perpetrators of abuse

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## Section Six – Conclusions

6.1 This case that demonstrates clearly that the indicators of domestic abuse should always be shared and considered fully across agencies.

6.2 Whilst one only report was received, that report related to a serious incident that was not recognised for the underlying seriousness which it betrayed. It is likely that several factors affected that thinking - the age of those involved; their health at the time and the emotive circumstances in which it was raised. Nonetheless, the real issues in the case were not identified.

6.3 It is also clear that the age of the perpetrator and victim did affect their own thinking; the perpetrator of this homicide did not tell anyone about the abuse he was suffering for years, and he declined support when it was offered after his wife's overdose. His wife also resisted any suggestion that she may be becoming unwell and seemed to resent those who tried to help her. This is perhaps a generational issue that all organisations need to continue to consider when concerns are raised and offers of assistance declined.

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