EXECUTIVE SUMMARY

of

DHR W04 2020

Domestic Homicide Review

into the death of a lady

Poppy

aged 80 years

in February 2020

Report by: Malcolm Ross M.Sc

Date: June 2022

Contents

List of Abbreviations

A&E	Accident and Emergency Department (Hospital)
AMHP	Approved Mental Health Practitioner
CCG	Clinical Commissioning Group
CCJW	Christian Congregation of Jehovah's Witnesses
CRCCG	Coventry and Rugby Clinical Commissioning Group
CSP	Community Safety Partnership
CT Scan	Computed Tomography Scan
CWPT	Coventry and Warwickshire Partnership Trust
DASH	Domestic Abuse, Stalking and Harassment assessment
DHR	Domestic Homicide Review
FACS	Fair Access to Care Services
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IMRs	Individual Management Reviews
MAPPA	Multi Agency Public Protection Arrangement
MARAC	Multi Agency Risk Assessment Conference
NHS	National Health Service
SWCCG	South Warwickshire Clinical Commissioning Group
SSWCSP	Safer South Warwickshire Community Safety Partnership
SWFT	South Warwickshire NHS Foundation Trust
WCC	Warwickshire County Council
WAHT	Worcestershire Acute Hospital NHS Trust
WNCCG	Warwickshire North Clinical Commissioning Group

Introduction and Background

The Domestic Homicide Review Panel express their sincere condolences to the family of Poppy who died in February 2020 and of Dad who died in April 2020, whilst in hospital.

The son of Poppy and Dad and his partner, have chosen the pseudonyms. The wife and husband will be referred to by those names throughout this report.

1. Introduction

1.1 This Domestic Homicide Review concerns the death of an 80 year-old woman, Poppy, who was killed by her 82 year old husband Dad, in their family home in Warwickshire in February 2020. Following his arrest, Dad was detained in hospital to await trial at the Crown Court but sadly died in hospital within a short time from Acute Kidney Injury, Inanition, Congestive Cardiac Failure, Atrial Fibrillation, Frailty, Oesophagitis and a lack of adequate nutrition and hydration, due in part to his wilful refusal to accept food and drink provided to him, but also his difficulty in swallowing food.

1.2 The couple had been married for some 61 years. They had four children, three boys and one girl. Unfortunately one of the boys and the girl died some time ago, leaving two boys, one of which had been estranged from the family for a number of years. He is now in communication with his brother. There is no evidence whatsoever of any issues regarding conflict between the couple and nothing to suggest of any history of domestic abuse between them.

1.3 The circumstances of the murder are clear. Dad admitted all that he had done. Poppy slept in the lounge of their bungalow due to her immobility problems. Dad slept in the bedroom. During the early hours of a Monday in February, Dad got up from his bed, went into the kitchen and got a kitchen knife from the drawer. He went into the lounge and stabbed his sleeping wife, Poppy, to death in her chair. He returned to bed but left several messages on the voicemail of a friend explaining what he had done. Those messages were picked up by the friend around 06.30 that morning. He went to the home address and found Poppy in her chair.

1.4 The emergency services were called. The ambulance personnel that attended declared Poppy dead at the scene. A police investigation commenced and Dad was arrested and interviewed and readily admitted killing his wife, but was unable to explain the reason behind his actions.

1.5 A Home Office post mortem revealed that Poppy had died from multiple stab wounds.

1.6 In accordance with Home Office Guidance[1] a Domestic Homicide Review has been commissioned.

1.7 The Terms of Reference and other administrative issues are contained in an appendix to this report.

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

Subjects of the Review

1.8 The following genogram identifies the family members, friends and colleagues in this case, as represented by the following key:

Victim	**Poppy**
Perpetrator	**Dad**
Son No 1	**Did not engage with the review process**
Son No 2	**Deceased**
Son No 3	**Engaged with process**
Daughter	**Deceased**

Review Process

1.9 The Safer South Warwickshire Community Safety Partnership (SSWCSP) was notified of the death of Poppy by Warwickshire Police in February 2020. The SWCSP reviewed the circumstances of this case against the criteria set out in Government guidance[2] and contacted the Home Office for advice on 19th March 2020. The advice from the Home Office was the circumstances met the criteria and a DHR was justified.

1.10 An Independent Chair and Author was commissioned on Friday 1st May 2020, and a DHR panel was identified. At the first review panel meeting terms of reference were agreed.

1.11 Home Office Guidance[3] recommends that reviews should be completed within 6 months of the date of the decision to proceed with the review. The Community Safety Partnership (CSP) has attempted to conform to this timescale.

1.12 On 5th February 2021, the SWCSP approved the final version of the overview report and its recommendations, although there were some amendments to the report further to input from Christian Congregation of Jehovah's Witnesses (CCJW). On 24th May 2022, the report was re-presented to the SWCSP Board and was accepted as being the final version.

Contributors to the review – Individual Management Reports.

1.13 An Individual Management Report and comprehensive chronology was requested from the following organisations:

- South Warwickshire CCG for Primary Care
- Coventry and Warwickshire Partnership Trust
- Warwickshire Police

[2] Home Office Guidance 2016 Page 9

[3] Home Office Guidance 2016 page 16 & 35

- South Warwickshire NHS Foundation Trust
- Worcestershire Acute Hospitals NHS Trust

1.14 Reports of information were provided by:

- Housing (Orbit Housing)
- Adult Social Care

Review Panel Members

1.15 In accordance with the statutory guidance, a Panel was established to oversee the process of the review. Mr Ross chaired the Panel and attended as the author of the Overview Report. Other members of the panel and their professional responsibilities were:

- **Karin Stanley –** Stratford CSP Lead
- **Jim Essex** – Police Staff Manager Statutory & Major Crime Review Unit (SMCRU) Warwickshire Police
- **DC Sarah Williams** - SMCRU (Statutory and Major Crime Review Unit)
- **Maxine Nicholls** - Lead Professional for Safeguarding Adults South Warwickshire NHS Foundation Trust
- **Julie Vaughan** – Lead Nurse for Adult Safeguarding Coventry & Warwickshire Partnership Trust
- **Andrew Meyer** – Organisational Safeguarding Lead, Orbit Group Ltd
- **Edward Williams** - Operations Manager Adult Social Care Warwickshire County Council
- **Rachel Jackson** –Lead Commissioner – Vulnerable People Warwickshire County Council
- **Rachel Shuter** – Service Manager Refuge
- **Cheryl Bridges** – Community Safety Manager Warwickshire County Council
- **Jonathon Toy** – Group manager Trading Standards and Community Safety WCC
- **Stavroula Sidiropoulou** – Domestic Homicide Review Officer
- **Frances Walsh** Named Professional for Safeguarding SWCCG (now CWCCG)

1.16 The Panel members confirmed they had no direct involvement in the case, nor had line management responsibility for any of those involved. The Panel was supported by the DHR Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur because of this review having been undertaken. The DHR panel met on the following occasions:

- 14th May 2020 (virtual meeting due to Covid-19),
- 26th June 2020 virtual,
- 28th July 2020 virtual
- 13th August 2020 virtual
- 16th October 2020 virtual
- 10th November 2020 with County Council Legal Representative

Independent Author

1.17 The Independent Author, Mr Malcolm Ross, was appointed at an early stage of this review. He is a former Senior Detective with West Midlands Police where he was responsible for around 85 homicide investigations many of them concerning domestic abuse/homicide cases. Since retiring in 1999, he has 22 years' experience in writing over 80 Serious Case Reviews and since 2011, performing both roles of Chair and Author in relation to]60 Domestic Homicide Reviews. Prior to this review he has not been involved either directly or indirectly with members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, (some of which were virtual meetings due to the Coronavirus), the members of which have contributed to the process of the preparation of the report and recommendations and have helpfully commented upon it.

Terms of Reference

1.18 The Terms of Reference for this review can be found at Appendix No.1 to this report.

2. Chronology/Summary of events.

2.1 The victim in this DHR was an 80 year-old married woman, Poppy, who had been married to her husband, Dad, for 61 years. Dad was 82 years old. They had four children, two of whom have died leaving two male siblings. The oldest of these has been estranged from his parents for some years. Both parents were white, British and followed the Jehovah's Witnesses religion.

2.2 The younger of the male siblings and his partner saw the couple on a regular basis. Both Dad and Poppy had significant medical health histories. Both had severe leg ulcers. In addition Poppy had a hiatus hernia, and she was diabetic. Dad had a heart complaint, he suffered from seizures, he relied on walking aids to assist his mobility and it was suspected that he may have had the onset of dementia.

2.3 They lived together, both of them caring as best as they could for each other. Both of them used wheelchairs.

2.4 Dad was a member of a local congregation of Jehovah's Witnesses and attended meetings at the local Kingdom Hall. He would regularly go from door to door preaching the word of the Bible with other Witnesses. Even when his mobility became problematic he would still insist on his preaching duties. One of his friends was an elder in the local congregation.

2.5 For many years, almost on a daily basis Poppy had visits from a District Nurse who treated her ulcerated legs. The same nurse treated Dad when his legs deteriorated. This nurse had a good relationship with the couple and her presence offered the opportunity for either of the couple to disclose any issues of domestic abuse but that was never the case.

2.6 In one particular week in February 2020, several events occurred which in retrospect may have indicated that things were coming to a head as far as Dad was concerned.

2.7 The couple had ordered a new freezer and when it arrived it turned out to be an American make. The accompanying instruction booklet referred to the unit as a refrigerator. Dad misinterpreted this American terminology and thought he had taken

delivery of a fridge and not a freezer. He was angry and upset until his son and his partner reassured him.

2.8 Dad expressed a wish to his friend from the local congregation that he wanted to arrange for a solicitor to organise the Power of Attorney for him and his wife. He asked the friend to identify a solicitor and make the arrangements but he made it clear that he would pay the solicitor on the day for his services. The solicitor arrived in the afternoon on a Friday in February 2020 and the documentation was completed. Dad offered to pay there and then but the solicitor told him that it was unlikely that his office staff were still at work at that time on a Friday afternoon and for Dad to contact the office on the following Monday morning and pay over the phone. Dad became annoyed and insisted paying at that time and said 'Monday will be too late'. The solicitor contacted his office and managed to find a member of staff to take the payment.

2.9 Nothing occurred during the next two days until the friend looked at his phone first thing on Monday morning to see that he had several missed contacts from Dad during the early hours of that day. On contacting Dad he was told that he had killed Poppy. Emergency services were contacted and Police Officers attended and found the body of Poppy in her chair in the lounge where she always slept.

2.10 Dad was seen by a variety of medical professionals to ensure his fitness to be detained and interviewed. He was eventually interviewed and fully admitted what he had done but was unable to explain the motive as to why he had done it.

2.11 The friend provided a statement to the Police and subsequently communicated with the Overview Author and it appears that during a conversation with his friend a couple of weeks before the death of Poppy, Dad, whilst explaining how low he felt and that he had financial worries at that time, indicated that he had been thinking about stabbing his wife to death and then killing himself. Considering that this was a passing comment whilst not feeling well, Dad's friend, quoted scriptures from the Bible to Dad.

2.12 At an Inquest touching into the death of Poppy, HM Coroner for Warwickshire set out that he was satisfied that the friend had acted reasonably and that it was reasonable for him to have considered the remark made by Dad as not a serious one but a remark made out of frustration.

2.13 During interview with Police Officers, Dad described how he found it difficult to manage with his own and his wife's mobility, ulcerated legs and constant need for care.

2.14 Whilst in Police custody Dad was taken to hospital feeling unwell. He was checked and discharged back to the Police. He was charged with the murder of his wife and appeared before the Magistrates. He was due to appear before the Crown Court but was again taken to hospital feeling unwell. He was examined and discharged. He was remanded by the Crown Court to a local prison but he was taken ill and again taken to hospital from prison with severe renal failure and heart failure. In April 2020 Dad died on the frailty unit ward at the local hospital.

3. VIEWS OF THE FAMILY AND FRIENDS

3.1 The Overview Author has had significant contact with the younger of the two surviving sons. He has also spoke with the friend. A full account of those contacts can be found in the Overview Report.

4. ANALYSIS AND RECOMMENDATIONS

4.1 On examination of the information regarding this DHR it was clear that the majority of the information would originate from health agencies. Adult Social Care had limited contact and Orbit (housing) who owned the house the couple were renting only had contact as landlord and tenant and periodically due to the need to do some repairs to the house. The main health agencies involvement are again explored in detail in the Overview Report but for the purposes of this Executive Summary each of their involvements is summarised.

4.2 Worcestershire Acute Hospital NHS Trust had contact with both Poppy and Dad individually. The IMR indicates that all contacts were within expected policies and practises regarding Poppy and Dad's ongoing and significant health needs. There is no indication to any professional from this Trust that either Dad or Poppy made any disclosures regarding any form of domestic abuse. The Trust identifies six areas of good practice which are contained in the Overview Report.

4.3 Coventry and Warwickshire Partnership Trust only had contact with Dad following the death of Poppy. Their IMR describes how he was depressed and his memory deteriorated to such an extent that he was unable to recall preaching from the Bible. He indicated that he doted on Poppy but he was frustrated about her lack of ability to grasp things. He reported increasing thoughts to harm his wife and stated he had acted on a split second decision.

4.4 South Warwickshire NHS Foundation Trust provided significant District Nurse services for both Poppy and Dad. There was continuity with the same District Nurse treating them for their leg ulcer complaints and a good relationship was built between the District Nurse and Dad and Poppy. The District Nurse was able to state that she thought that Dad was a very independent person who saw his role in life was to look after Poppy. He found it degrading to ask for help but at times this came across as him being aggressive. Poppy on the other hand was forgetful and it was clear that Dad found it difficult to cope with her needs. Equally Poppy found it difficult to care for Dad's needs.

4.5 After reviewing the documentation, South Warwickshire NHS Foundation Trust have made three formal recommendations for their Trust.

- To work in conjunction with the Clinical Audit Department to assess the quality of the electronic record keeping. This will be carried out by enquiring what record keeping audits are in place and how they may include quality and analysis of note keeping.
- To work with Operational Managers within District Nurse Services and Podiatry and the training department to offer Domestic Abuse and DASH Safeguarding Training appropriate for their role in adherence with Adult Safeguarding Roles and Competencies for Health Care Staff 2018. This will be part of the training for all health professionals within the Trust.
- To write a multi-agency training package across the Health Economy to consider Older Adult Domestic Abuse

4.6 The South Warwickshire Clinical Commissioning Group (CCG) IMR indicates that the surgery had regular contact with both parties due to their multiple medical conditions. No one in the surgery felt that they could have predicted what had happened. The IMR stresses that both parties had been seen at home, in the surgery, alone and together where they had ample opportunity to disclose any concerns that they had. The IMR

points out, however, that whilst there was no indicator of domestic abuse there is no documentary evidence that the question was ever directly asked by the GP. It also points out that the surgery is an IRIS accredited practice and had any disclosure of that nature been made, staff at the surgery would have been well prepared to take action in accordance with the IRIS Pathways. The regular 'Routine Enquiry' into the possibilities of domestic abuse which is recognised as best practice did not occur.

Recommendation No 1

South Warwickshire Clinical Commissioning Group, Coventry and Warwickshire Partnership Trust and South Warwickshire NHS Foundation Trust reassure the South Warwickshire Community Safety Partnership that the recommendation of the SWP DV Strategic Review, i.e. that Routine Enquiry into Domestic Abuse is embedded into training, policy and procedure.

4.7 Both Dad and Poppy were members of a local congregation of Jehovah's Witnesses and had been for some years. Dad had actually stopped being a member, but according to his son, Dad returned to the religion once he had retired from work. Dad was a regular attender at meetings at the local congregation (which took place in the local Kingdom Hall), which was a registered charity, under the Charity Commission rules and regulations. Within the congregation are elders, senior members of the congregation and Ministers. One such elder became a friend of Dad and would see him on a regular basis at meetings at the Kingdom Hall.

4.8 A short time before the death of Poppy, the friend visited Dad at his home. Poppy was also there. According to the friend, Dad was not feeling too well and he told the friend that he was thinking of ending his and Poppy's life. He described that he would get a knife and kill Poppy and then himself. When asked by the Review Author what he did when he heard Dad say that, the friend said that he read Dad a single verse from the Bible about dealing with anxiety. The friend stated that he did not think any more of the comment other than it was a 'throw away comment'.

4.9 Dad asked the friend if he knew a solicitor who could arrange wills and Power of Attorney for both Dad and Poppy. The friend knew such a solicitor and arrangements were made for the solicitor to attend the family home, with a secretary as a witness 3 days before the death of Poppy. The friend was also present. The solicitor finalised the will and Power of Attorney papers later on the Friday afternoon. Dad insisted on paying there and then but the solicitor asked him to call the office on the following Monday and pay over the phone. The friend described how Dad became a little agitated and insisted on paying at that moment saying "Monday will be too late". Neither the solicitor nor the friend saw any significance in that comment. The solicitor thought the comment referred to a hospital appointment he had been told by the friend that Dad had on the following Monday. The friend said that he thought it was another 'throw away comment'.

4.10 The Author asked the friend about the safeguarding policies within Jehovah's Witnesses. The friend explained that he was not aware of a written policy in relation to adult safeguarding.

4.11 The Report Author spoke to two representatives of CCJW and discussed Charity Commissions guidance regarding the safeguarding of adults and children.

4.12 On having sight of the Overview Report , the representative of CCJW that the Report Author spoke to said that:

> "Need to be careful not to conflate what is legally required and what one may choose to do out of moral or religious feeling or responsibility. Care Act and Safeguarding Vulnerable Groups Act (where vulnerable adults legally defined) does not apply to the religious activity of Jehovah's Witnesses as the scope of congregation activity does not extend to care of, or regulated activity with, such groups. As a religion Jehovah's Witnesses do publish much literature for the benefit of adherents to the wider public on how ones can take reasonable steps to protect for example their mental health etc but that this is distinct from a legal duty to have a policy to take certain steps- not aware of any such legal requirement".

4.13 On 28th April 2021, HM Coroner for Warwickshire held an Inquest into the death of Poppy. The Coroner heard evidence from the elder from the local congregation of Jehovah's Witnesses, (Dad's friend), the family members and from the author of this DHR. The Coroner determined that Poppy had been unlawfully killed. Having heard evidence during the Inquest proceedings the Coroner set out that he was satisfied that the friend had acted reasonably [after Dad's disclosures] and that it was reasonable for him to have considered the remark made by Dad as not a serious one but a remark made out of frustration.

4.14 At the conclusion of the Inquest touching into the death of Poppy on 28 April 2021, HM Coroner for Warwickshire made a Regulation 28: Report to Prevent Future Deaths under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. That Report was addressed to CCJW and set out that during the course of the inquest it was accepted that the CCJW do not have any policy regarding safeguarding of vulnerable adults who are members of the congregation and that the issue of such a policy was raised by the author of the Domestic Homicide Review into Poppy's death with the CCJW in October 2020. The Report set out that the reply from the CCJW was unclear whether they propose to adopt such a policy or not. HM Coroner for Warwickshire held that action should be taken to avoid future deaths and that the CCJW have the power to take such action. HM Coroner made it clear that he was making the Regulation 28 report, not because he considered that the absence of a policy made any difference in this case, but so that CCJW could explain its thinking. On 17 June 2021 CCJW responded to HM Coroner for Warwickshire's Regulation 28: Report to Prevent Future Deaths.

4.15 A more global adult abuse policy for the charitable organisations that concern themselves with the Jehovah's Witnesses' faith and indeed any other faith based groups in Warwickshire, would offer structure and guidance on how to respond to abuse/neglect concerns that affect adults, how to address domestic abuse issues and then how to address those concerns should the adult have needs for care and support such as reporting concerns to Adult Social Care or other statutory agencies.

Best practice advice

The charitable organisations of faith based groups operating in Warwickshire (locally or nationally) should ensure a structured policy on adults' abuse and neglect is written which should include reference on how to respond to concerns of abuse or neglect of older people and adults at risk of domestic abuse, and how to respond to the abuse or neglect of adults with care and support needs. The policy should be embedded into training for Elders, Ministers and Trustees of faith based groups to recognise the signs and be aware of the referral process to statutory agencies.

Recommendation No 2

Warwickshire Safeguarding Adults' Board to consider a means and seek assurance from other Warwickshire faith based groups that they have written structured Safeguarding Policies.

4.16 The Overview Author has been in contact with the Charity Commission, about the circumstances outlined in this review.

Recommendation No 3

South Warwickshire Community Safety Partnership Board ensures that the Charity Commission be provided with a copy of this Domestic Homicide Review.

4.17 South Warwickshire NHS Foundation Trust make three recommendations in their IMR:

1. To work in conjunction with the clinical audit department to assess the quality of the electronic record keeping. This will be carried out by enquiring what Record Keeping audits are in place and how they may include quality and analysis of note keeping.

2. To work with Operational Managers within DN services and Podiatry and the training department to offer Domestic Abuse and DASH safeguarding training appropriate for their role in adherence with Adult Safeguarding Roles and Competencies for Healthcare Staff, 2018. This will be as part of the training for all health professionals within the Trust.

3. To write a Multi-agency training package across the Health Economy to consider Older Adult Domestic Abuse.

5. Conclusions

5.1 This DHR concerns the death of an elderly lady by her elderly husband. Both of them had significant medical needs which were being catered for by a professional team of District Nurses. As and when required both Poppy and Dad had hospital appointments. On each contact they were dealt with in a professional manner within due bounds of agency guidance, policies and procedures. There was very little involvement from Adult Social Care as most of their needs were medical. Their housing association, Orbit, did what they could for them in terms of a bathroom conversion and repairs. There was no other agency involvement.

5.2 The best practice advice to faith based charitable organisations are made with the intention of encouraging policy and procedures to safeguard adults (and children).

5.3 The motive behind the death of Poppy will never be known. Whilst Dad admitted the actual killing, he gave no insight as to the motive.

5.4 The Panel offer sincere condolences to Poppy and Dad's family. Special appreciation goes to the son and his partner who have been extremely helpful during the process of this review and without their assistance this review would have been much more difficult.

Summary of Recommendations

Recommendation No 1 **Page 10**

Coventry and Warwickshire Clinical Commissioning Group, Coventry and Warwickshire Partnership Trust and South Warwickshire NHS Foundation Trust assure the Safer South Warwickshire Community Safety Partnership that the recommendation of the SWP DV Strategic Review, i.e. that Routine Enquiry into Domestic Abuse is embedded into training, policy and procedure.

Best practice advice **Page 11**

The charitable organisations of faith based groups operating in Warwickshire (locally or nationally) should ensure a structured policy on adults' abuse and neglect is written which should include reference on how to respond to concerns of abuse or neglect of older people and adults at risk of domestic abuse, and how to respond to the abuse or neglect of adults with care and support needs. The policy should be embedded into training for elders, Ministers and Trustees of faith based groups to recognise the signs and be aware of the referral process to statutory agencies.

Recommendation No 2 **Page 12**

Warwickshire Safeguarding Adults' Board to consider a means and seek assurance from other Warwickshire faith based groups that they have written structured Safeguarding Policies.

Recommendation No 3 **Page 12**

South Warwickshire Community Safety Partnership Board ensures that the Charity Commission be provided with a copy of this Domestic Homicide Review.

Agency Recommendations

South Warwickshire NHS Foundation Trust

1. To work in conjunction with the clinical audit department to assess the quality of the electronic record keeping. This will be carried out by enquiring what Record Keeping audits are in place and how they may include quality and analysis of note keeping.

2. To work with Operational Managers within DN services and Podiatry and the training department to offer Domestic Abuse and DASH safeguarding training appropriate for their role in adherence with Adult Safeguarding Roles and Competencies for Healthcare Staff, 2018. This will be as part of the training for all health professionals within the Trust.

3. To write a Multi-agency training package across the Health Economy to consider Older Adult Domestic Abuse.

Malcolm Ross M.Sc

Independent Author and Chair of Domestic Homicide Reviews

June 2022

Appendix No 1

TERMS OF REFERENCE

1. Supporting Framework

1.1. The Domestic Homicide Review (DHR) is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

1.2. In this section “domestic homicide review” means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by

A person to whom he was related or with whom he was or had been in an intimate relationship; or

A member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.3. Where the definition, set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

2. Purpose of the DHR

2.1. Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

2.2. Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

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

2.4. Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

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

2.6. Highlight good practice.

3. Methodology

3.1. This DHR will primarily use an investigative, systems focus and Individual Management Review (IMR) approach. This will ensure a full analysis by the IMR author to show comprehensive overview and alignment of actions.

3.2. This will ensure that practical and meaningful engagement of key frontline staff and managers will be carried out by the IMR author on a more experiential basis than solely being asked to respond to written conclusions or recommendations.

3.3. This is more likely to embed learning into practice and support cultural change where required.

4. Scope of the DHR

4.1. Victim: Poppy

4.2. Perpetrator: Dad

Timeframe

4.3 The period of this review will be from 1st January 2014 (the date that the health of both Poppy and Dad started to deteriorate) to the end February 2020, (nearly 2 weeks after the death of Poppy).

4.4 In addition agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of this adult and include information around wider practice at the time of the incident as well as the practice in the case.

4.5 The Terms of Reference will be a standing item on the agenda of every panel meeting in order the we can remain flexible in our approach to identify learning opportunities.

5 Agency Reports

5.4 Agency Individual Management Reports will be commissioned from:

- Warwickshire Police
- Warwickshire CCG
- Coventry and Warwick Partnership Trust

Other reports for those agencies having limited contact with the Victim and Perpetrator:

- Housing (Orbit Housing)
- Adult Social Care

5.5 Agencies will be expected to complete a chronology and IMR. Template and guidance attached.

5.6 Any references to the adults, their family or individual members of staff must be in full and later redacted before submission to the Home Office or published.

5.7 Any reasons for non-cooperation must be reported and explained.

5.8 All agency reports must be quality assured and signed off by a senior manager within the agency prior to submission.

5.9 It is requested that any additional information requested from agencies by the DHR Independent Author is submitted on an updated version of the original IMR in red text and dated.

5.10 It is requested that timescales are strictly adhered to and it should be noted that failure to do so may have a direct impact on the content of the DHR and may be referred to in the final Overview Report to the Home Office

5.11 Agencies will be asked to update on any actions identified in the IMR prior to completion of the DHR which will be fed into the final report. Updates will then be requested until all actions are completed.

6 Areas for consideration

Poppy:

6.4 Was the victim recognised or considered to be a victim of abuse and did the victim recognise themselves as being an object of abuse?

6.5 Did the victim disclose to anyone and if so, was the response appropriate?

6.6 Was this information recorded and shared where appropriate?

6.7 Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of the victim and their family?

6.8 When, and in what way, were the victim's wishes and feelings ascertained and considered?

6.9 Is it reasonable to assume that the wishes of the victim should have been known?

6.10 Was the victim informed of options/choices to make informed decisions?

6.11 Were they signposted to other agencies?

6.12 Was consideration of vulnerability or disability made by professionals in respect of the victim and perpetrator?

6.13 How accessible were the services for the victim and the perpetrator?

6.14 Was the victim or perpetrator subject to a Multi-agency Risk Assessment Conference (MARAC) or any other multiagency forum?

6.15 Did the victim have any contact with a domestic abuse organisation, charity or helpline?

Dad:

6.16 Was the perpetrator recognised or considered to be a victim of abuse and did the perpetrator recognise themselves as being a perpetrator of abuse?

6.17 Did the perpetrator disclose to anyone, and if so, was the response appropriate?

6.18 Was this information recorded and shared where appropriate?

6.19 Was anything known about the perpetrator? For example, were they being managed under MAPPA, did they require services, did they have access to services.

6.20 Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of the victim and their family?

6.21 Were services accessible for the perpetrator? And were they signposted to services?

6.22 Was consideration of vulnerability or disability made by professionals in respect of the perpetrator?

6.23 Did the perpetrator have contact with any domestic abuse organisation, charity or helpline?

Practitioners:

6.24 Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?

6.25 Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Policy and Procedure:

6.26 Did the agency have policies and procedures in place for dealing with concerns about safeguarding and domestic abuse?

6.27 Did the agency have policy and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (e.g. DASH) and were those assessments correctly used in the case of this victim/perpetrator?

6.28 Where these assessment tools, procedures and policies professionals accepted as being effective?

7 Engagement with the individual/family

7.4 While the primary purpose of the DHR is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in, and across, agencies and services, it is imperative that the views of the individual/family and details of their involvement with the DHR are included in this.

7.5 South Warwickshire Community Safety Partnership, through the Independent Chair, are responsible for informing the family that a DHR has been commissioned and an Independent Chair has been appointed. The DHR process means that agency records will be reviewed and reported upon, this includes medical records of both the victim and perpetrator if consent is agreed by the Perpetrator.

7.6 Firstly, this is in recognition of the impact of the death of Poppy giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the

deceased helping the process focus on the victim's and perpetrator's perspectives rather than just agency views.

7.7 All IMRs are to include details of any family engagement that has taken place, or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the DHR in addition to the Police Family Liaison Officer, FLO, in respect of criminal proceedings.

8 Media Reporting

8.4 In the event of media interest, all agencies are to use a statement approved and provided by South Warwickshire Community Safety Partnership.

9 Publishing

9.4 It should be noted by all agencies that the DHR Overview Report will be published once completed, unless it would adversely impact on the adult or the family. Publication cannot take place without the permission of the DHR Home Office Quality Assurance Panel.

9.5 The media strategy around publishing will be managed by the DHR Panel in consultation with the chair of South Warwickshire Community Safety Partnership and communicated to all relevant parties as appropriate.

9.6 Consideration should be given by all agencies involved in regards to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware, in advance, of the intended publishing date.

9.7 Whenever appropriate and 'Easy Read' version of the report will be published.

10 Administration

10.4 It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via secure email account (GCSX) or through the Local Authority's Secure Communication System (SCS). Failure to do so will result in a data breach and must be reported to the Data Protection Commissioner.

10.5 The Domestic Homicide Review Officer will act as a conduit for all information moving between the Chair, IMR Authors, Panel Members and the DHR Panel.