Content warning: over 18s only

The following document contains material of a highly sensitive nature (including references to death, violence, and abuse) and may be upsetting for some individuals.

OVERVIEW REPORT

of the

DOMESTIC HOMICIDE REVIEW

relating to the death of Mrs A

on behalf of:
EAST SURREY COMMUNITY SAFETY PARTNERSHIP

Report author:	**Liz Borthwick** Independent Chair December 2015

CONTENT

PREFACE

The purpose of this review was to examine the circumstances surrounding the sudden unexpected death of Mrs A (the victim of the homicide) in the borough of Reigate and Banstead, Surrey and to identify the support offered by relevant agencies to Mrs A and to Mr A (the alleged offender) jointly and separately prior to their deaths in June 2015.

The review considers the issues identified in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (DHRs) issued under section 9(3) of the Domestic Violence, Crime and Victims Act (2004) and aims in particular to:

- establish what lessons are to be learned from the domestic homicide regarding how effectively local professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are, how and within what timescales they will be acted upon, and what is expected to change as a result;
- apply these lessons to service responses including changes to policies and procedures as appropriate; and
- prevent future domestic violence homicides wherever possible, through improved intra and inter agency working.

The DHR panel members wish to thank the family and friends who participated in the review. We understand what a difficult time this must be and offer our sincerest sympathies on their loss.

Timescales

The review began on 3 July 2015 and concluded on 18 December 2015**,** with submission to the Home Office on 21st December. The Home Office responded on 5th April 2016 proposing a number of changes (see Appendix 3). These have been incorporated into this document in relevant sections.

Confidentiality

The detailed findings of each review are confidential. Information is available only to participating officers / professionals and their line managers.

Dissemination

The Executive Summary and Recommendations have been redacted to ensure confidentiality and have been disseminated to the following groups:

- East Surrey Community Safety Partnership
- Reigate & Banstead Borough Council's Leader's Group
- Surrey Adult and Surrey Children Safeguarding Boards
- Surrey Community Safety Board
- The Office of Surrey Police & Crime Commissioner (OPCC)
- The agencies involved in the review
- The families of Mrs A and Mr A.

GLOSSARY OF ABBREVIATIONS USED IN THIS REPORT

ACMRR	Age Concern Merstham, Redhill and Reigate
CCG	Clinical Commissioning Group
CMHT OP	Community Mental Health Team for Older People
DHR	Domestic Homicide Review
ESAS	East Surrey Alzheimer's Society
ES CSP	East Surrey Community Safety Partnership
ICAD	Log of initial command and deployment
IMR	Individual Management Review
RBBC	Reigate & Banstead Borough Council
SaBP	Surrey and Borders Partnership NHS Foundation Trust
SASH	Surrey and Sussex Healthcare NHS Trust
SCC	Surrey County Council
SIRA	Serious Incident Requiring Investigation

	ES CSP DHR OVERVIEW REPORT **Mrs A (Date of death: 15 June 2015)**
1.	**INTRODUCTION**
1.1	This overview report has been commissioned by the East Surrey Community Safety Partnership (ES CSP) concerning the death of Mrs A in June 2015 apparently caused by her husband Mr A (deceased). The Independent Chair of the DHR Panel and author of this report is Liz Borthwick, who has no links with ES CSP or Reigate & Banstead Council, the area in which the incident happened. Liz is a former Assistant Chief Executive at Spelthorne Borough Council who has considerable expertise in Adult Social Care and Safeguarding, and has been involved in a number of safeguarding reviews.
2.	**PURPOSE OF THE REVIEW**
2.1	Domestic Homicide reviews became statutory under Section 9 of the Domestic Violence, Crime and Adult Act 2004 and came into force on 13 April 2011. The Act requires 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 they were either related, in an intimate personal relationship with or living within the same household
2.2	The Home Office's multi-agency statutory guidance for the conduct of a domestic homicide review states the purpose as being to; • establish what lessons are to be learnt from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims; • 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; • apply those lessons to service responses, including changes and policies and procedures as appropriate; and • prevent domestic violence homicide and improve service responses for all domestic violence victims and their children (if applicable) through improved internal and inter-agency working.

3.	**SUBJECTS OF THE REVIEW**
3.1	The main subjects of the review are:

DHR subject	**Date of birth**	**Date of death:**
Mrs A (female)	[redacted] 1935	15 June 2015
Mr A (male)	[redacted] 1938	15 June 2015

3.2	Mrs A and Mr A were both White British and in their late seventies. They had been married for over 40 years and had no children.
4	**Conduct of the review**
4.1	Following notification by Surrey Police of the death of Mrs A and Mr A on 15 June 2015, the Chair of ES CSP requested that a preliminary steering group be established to consider the case and whether to proceed with a full review. At the preliminary meeting on 3 July 2015 the steering group agreed that the circumstances of the review met the definition of a DHR which should therefore proceed.
4.2	The Chair of ES CSP notified the Home Office on 10 July 2015 that a domestic homicide review would now commence in the area covered by Reigate and Banstead Borough Council. The statutory six-month deadline for submitting the final Overview Report is 3 January 2016.
4.2	The Chair of ES CSP notified the Home Office on 10 July 2015 that a domestic homicide review would now commence in the area covered by Reigate and Banstead Borough Council. The statutory six-month deadline for submitting the final Overview Report is 3 January 2016.
4.3	An Independent Chair, Liz Borthwick was appointed and a Domestic Homicide Panel was convened comprising senior representatives from relevant partner agencies to oversee the review: • Liz Borthwick - Independent Chair • Peter Tonge - Reigate and Banstead Borough Council (RBBC) Head of Environmental & Community Regulations (*until 14 October 2015*) • Tom Kealey - RBBC Head of Health & Wellbeing (*from 15 October 2015*) • Debbie Stitt - RBBC Community Safety Manager • Teresa Hawkins - Surrey County Council, Assistant Area Director, Adult Social Care Service • Helen Blunden - Surrey Downs Clinical Commissioning Group (CCG), Designated Nurse for Safeguarding Vulnerable Adults • Michelle Blunsom - East Surrey Domestic Abuse Services Chief Executive • Chris Edwards - Surrey Police Superintendent Public Protection Donna Coulon - RBBC Democratic Services Officer - administration and support
4.4	Terms of Reference were agreed, including the timeframe for review (see Appendix 1).

4.5	Individual Management Reviews (IMRs) were requested from each agency in accordance with the statutory guidance. As the review progressed, further possible contacts with Mrs A and Mr A by other agencies were identified and additional information requested.
4.6	IMRs were commissioned from: • Surrey Police • Surrey Adult Social Care • Mr A and Mrs A's local medical practice ('R') • Surrey and Borders Partnership NHS Foundation Trust (SABP) • Spire Gatwick Park Hospital • Surrey and Sussex Healthcare NHS Trust (SASH) • First Community Health and Care
4.7	The panel has given detailed consideration and professional challenge to the IMRs submitted by these agencies and the final documents have contributed significantly to this report.
4.8	This document has also been supplemented by a number of interviews / conversations with friends and neighbours in an attempt to understand the personal backgrounds of Mrs A and Mr A and to identify if there had been any previous concerns about domestic violence. These interviews were especially important as Mrs A and Mr A had no children, had relatives living in a different part of the country and appear to have been very private people; gaining insight into their lives prior to the incident has been challenging.
4.9	Investigations by the Independent Chair relating to the victim, Mrs A, took place as detailed below: • A number of telephone interviews with Mr A's sister • Information from neighbours including telephone interviews based on intelligence from police reports • Telephone discussions with friends and colleagues • Meetings with voluntary sector providers in the relevant area who support older people and people with mental health problems. This included Age Concern Merstham, Redhill & Reigate (ACMRR) and East Surrey Alzheimer's Society (ESAS) • Discussions with other relevant community workers • Telephone interviews with relevant sports clubs where Mrs A and Mr A participated (gun club and golf club) • Telephone interview with senior officers in East Surrey Clinical Commissioning Group (ES CCG)
5.	**OVERVIEW OF FAMILY LIFE**

5.1	This section of the report provides information about Mrs A and Mr A prior to their deaths, gathered from a range of sources as listed above.
5.2	Mrs A and Mr A married over 40 years ago in Leicestershire. Following their marriage they moved down as a couple to Redhill. Mrs A worked full time in the City, where she invested money for charities, until her retirement a number of years ago. Mr & Mrs A appear to have led fairly active lives until 2015.
5.3	Mrs A enjoyed playing golf and bridge and on retiring often played three times a week at a number of local golf clubs. It seems that Mrs A stopped playing golf at her main club about two years prior to her death.
5.4	Mr A initially carried out voluntary work at a local gun club where he was an active member, participating in about six shoots a year until he ceased in early 2015. He then began working at a local farm, which he continued to do until his death. He came from a farming family and learnt to shoot as a child. Friends of Mr A stated that he was very trustworthy, very well liked and a hard worker.
5.5	Mrs A and Mr A had no children. Mrs A had no siblings, the closest relative being a cousin (who chose not to be involved in this review). Mr A had a sister and nieces living in Rugby at the time of death. Members of the family and neighbours have said that Mrs A and Mr A were a very private couple.
5.6	Mrs A had rheumatoid arthritis and Gilberts Syndrome, a mild blood disorder. Medical feedback states that Mrs A was responding well to her treatment for rheumatoid arthritis and before her death it appears she was planning to go on a golfing holiday with Mr A.
5.7	Mr A had a severe hearing impairment (approximately 75% loss) since he was a child, which, according to a family member, was hereditary. Mr A had a hearing aid but found it difficult to use the phone, preferring to write to his family. It appears that sometimes his deafness made him feel isolated.
5.8	Mr A talked to his sister approximately every six weeks and used to visit her on his own about twice a year. Mr A last visited his sister before Christmas 2014 and was reported to have looked well.
5.9	Mr A's sister reported that in a letter written by him in March 2015, he had stated that Mrs A's memory was "going" but that Mrs A did not see this as a problem. In one letter Mr A asked the family not to phone as if Mrs A answered then she would say that Mr A was telling tales.
	Voice of the Victim

5.10	It was a challenge for this review to find out more personal information about Mrs A to build up a picture of her and her husband as 'real people'. Information came predominantly from health agencies that Mrs A was involved with and
	from Mr A's family and friends. The Chair of the panel tried to gain further information about Mrs A from her golf associates but this proved unsuccessful.
5.11	Due to the age of the couple, it was difficult to find friends and colleagues to interview, as a number of potential contacts had since deceased. Contacting Mrs A's employer was inappropriate due to the length of her retirement.
6.	**EVENTS LEADING TO THE DEATHS ON 15 JUNE 2015**
6.1	On 13 June 2015, a neighbour of Mr & Mrs A stated that she saw Mr A moving his car on the drive. Mr A was in an agitated state, saying he could not cope anymore.
6.2	On 15 June 2015, another neighbour was aware that Mrs A had a hospital appointment. The neighbour noticed the curtains of the house had not been opened and that the car was still in the drive. The neighbour banged on the door but no one answered. She became concerned and phoned Surrey Police.
6.3	Surrey Police made checks of local hospitals and ambulance services to clarify whether there had been any contact with either Mrs A or Mr A, which proved negative. The police were then deployed to their home address. Surrey Police stated that there was no sign of disturbed entry on arrival and they had to force entry themselves.
6.4	The Police found Mr A lying in the hallway with a rifle in his hand and an apparent gunshot wound to his mouth.
6.5	Mrs A was found in the rear bedroom (location of the gun safe) with an apparent gunshot wound to the back of her head. She was dressed in a nightgown and wearing an incontinence pad.
6.6	Both Mrs A and Mr A were cold to touch and showed no signs of life.
6.7	Toxicology tests showed no evidence of Mrs A having been sedated in any way. Although not fully conclusive, but highly probable, forensics identified that the gun and ammunition used appears to have been the same in both deaths and was licensed to Mr A.

6.8	A search by the police of the property located a 2015 diary, which belonged to Mr A. The following extracts are shared to provide an insight into how Mr A perceived the deterioration of his wife's health and the impact it had on him. This information was seen by anyone else until after their deaths on 15 June. The name of the GP referred to has been replaced with "F" for confidentiality purposes and Mr A's nickname for his wife has been redacted. Other identifiable information has been anonymised.

Date of entry (all 2015)	Diary Entry
9 January	*'[redacted] to Dr F 30 January 2015 at 10 am. My husband wants me to tell you he thinks I am having difficulty getting my thoughts together. I am not certain I agree with him but I am certain that it is difficult to do the right thing in the current climate' "* This appears to have been written by Mr A and to refer to what Mrs A had said on the phone to her doctor.
21st - 23rd March	*'[redacted] very confused and forgetful" "Still a bit confused & forgetful"* *"Still a bit forgetful & confused. I think a bit better"*
26th March	*'[redacted] seems to have problems remembering & sorting facts out. I [redacted] asked if she would like to see the nurse or doctor. She said 'No, do you' "*
27th March	*'[redacted] a bit better today. She phoned the (*Medical Practice R*) to make an appointment to see Dr F no problem"*
28th / 29th March	Mrs A able to make phone call re golf holiday
30th March	*'[redacted] seems a lot brighter today. Saw Dr F. Gave her simple memory test like putting the figures on a clock diagramme (sic) and remembering a name address, major current affairs. Then after a while could she still remember the name and address again"* *"Dr F said if [redacted]'s condition deteriorated a lot to make an appointment to see him"*
28th April	*"Still didn't want to see Dr F. I have to be a bit careful how I say it"*
1st May	*"I think we must try to see Dr F again after the holiday. When I ask her if she is OK she says stop worrying, I'm alright and then goes back to sleep"*
4th May	*"She had a little accident in the bed am"*
5th May	*"We went down to the (surgery R) to get an appointment with Dr F. Short-term memory loss - Is it permanent.* *Have you had any advice, support or help NO"* (large letters)
6th May	*"Saw Dr F.* *Went back at 11.00 for ECG. Surgery phoned to ask [redacted] to make an appointment for 9am Friday"*
7th May	*'[redacted] came down a.m. in just her undies. Needs more help getting dressed and getting off the loo"*

8th May	*"Big check over by Dr F. No mention of memory loss! He said she had a heart malfunction."* *"His only reference to memory loss was 'It was only a week before you came to see me on 30th March which is only 4 or 5 weeks ago' "*
10th May	*"She had an "accident" and soiled her pants and trousers this afternoon. I didn't find out till it was time for bed"*
12th May	*'[redacted]as usual. Needs telling to do everything in the morning. Wait till I come up to get her. Put cream on her legs help her get dressed & get downstairs. Help her with her breakfast and give her the tablets"*
17th May	*"I'm trying to get rid of rubbish but -[redacted] wants to keep everything. It's ridiculous (sic) She makes a fuss over everything"*
23rd May	*'[redacted]weed on the carpet and wet her pants. Poor[redacted] she thinks nothing of it* *[redacted]double incontinent evening.* *[redacted]…rambles on about redulous (sic) thoughts. No sense at all in what she says yet if something comes in the post like a Divi cheque from* (Investment company) *she knows what it is quick* *I can't cope without[redacted] 's 'ears and brains'. On my own. No help or Support"*
26th May	*"Dr F 9.30* *Wet her knickers and the bed* *God I need to calm down* *Told doc I could cope with everyday problems or I could cope with[redacted] but the 2 together was too much of a strain. I'm the weak link. No comment"*
28th May	*'[redacted]wet the carpet. She makes nonsense remarks. She then has a vacant expression. Then goes off to sleep with her head on the table. To sleep with her head on the table she has got to have dementia or Alzheimer. It's so tragic. She said 'We had lovely gravy at Tandridge' 'The building was lovely dark stone".* *I've never been to Tandridge.* *I must try to distance myself from[redacted] 's ramblings"*
29th May	*'[redacted]wants to carry on, I don't think I can" <u>Problems</u>* *[redacted], what for future?*

30th May	*" [redacted] wet her pants, the duvet, the mat & the carpet. It's not going to stop! She thinks it's alright"* *"[redacted] has just put the tomato sauce in the gherkins lid and eating them out of the jar. She has just been singing out loud".* *"Our beautiful world has died with dementia and deafness and my*

	inabilities"
2nd June	*"(X) Echocardiogram clinic"* [redacted]*says she can't go to (X) Call it off"*
3rd June	*"Sorry everybody* *I can't cope anymore* *See notes"* (large letters) *"The last 3 months have been the worst of my whole life"*
4th June	*"Wee all over the duvet and sheet"*
5th June	*"Pee in the bed, the mat, the cover, the carpet* *So help me can't cope* *Car* *Boiler,* *Clinics* *Prescri* *pts Pills* *& washing / doing shopping* *It's going on for ever"*
10th June	*"Damn I've got depression. Can't do anything* *The coming programme is too daunting for me* *Need someone to help me* *WHO?* *Kind Dr F phoned.* [redacted]*copes well on the phone"*
12th June	*The front room rads are* *leaking <u>HELP</u>* *I need a plumber. Can't hear* (large letters)
14th June	*No entry*
15th June	*"CT? scan Gatwick Park 2.00pm* *Leave 1.15 or 1.00"*
	No further entries

6.9	Surrey Police also found an unopened letter postmarked 3 June 2015 and a further note in handwriting assessed to be consistent with Mr A's diary. These read: *'You are looking for an easy way out well there isn't one?'* and *'Help'* which followed the words *'I cannot cope'*.
6.10	An investigation was commenced by Surrey & Sussex Major Crime Team under the operational banner 'Operation Ube'. The investigation proved that there was no third party involved. At the time of report submission, the Coroner had yet to complete the inquest, although the investigation has confirmed that no third party was involved.
7.	**ENGAGEMENT WITH OTHER AGENCIES AND IMR FEEDBACK**
7.1	This section has been compiled from the Individual Management Reviews (IMRs) submitted by the agencies involved in this case. The objective of the IMRs was to provide an accurate account of agencies' involvement with Mrs A and Mr A up to the date of their deaths, evaluate their actions and identify improvements for the future.
7.2	In some cases, agencies have identified changes in practice which they then implemented during the period of the review to improve awareness of and responses to cases of domestic abuse. All IMRs have been challenged robustly by the panel and, where appropriate, have been subject to review and revision.
7.3	**Surrey Police**
7.3.1	Surrey Police confirmed that their previous involvement with the couple had only been with Mr A, a registered firearms, shot gun and explosives holder since 8 November 1980.
7.3.2	At his last license renewal on 4 August 2012, Mr A was in legal possession of the following equipment: • 2 x .45 Perdersoli Muzzle Loading Rifles • 7.62 Swing Bolt Action Rifle • .22 Mauser Bolt Action Rifle *(believed to have been the weapon used in this incident)* • Greener 12 Bore Single Barrelled Shot Gun • 75 x rounds of 7.62mm ammunition • 90 x rounds of .22 ammunition • A quantity of black powder for use in muzzle loading rifles.
7.3.3	On 24 August 2012 a Firearms Enquiry Officer carried out a firearms security visit at Mr A's home address which provided an opportunity to meet with Mr A face to face. Mr A stored the guns in an approved cabinet bolted to the first floor bedroom wardrobe (the room in which Mrs A was

	found dead). Mr A fulfilled all the criteria for the possession of a firearms' licence. He was seen as a reliable member of his rifle club and no concerns had been reported about Mr A's suitability to continue to own firearms.
7.3.4	Surrey Police had brief contact with Mr A relating to a report by a resident living on the same road on 18 July 2014. The resident reported he had seen an older female on a mobility scooter acting suspiciously close to a vehicle owned by Mr A which was one of a number in the street that had sustained some damage.
7.3.5	Surrey Police had no contact with Mrs A and there was no information within the records held by the Firearms Licensing Department to indicate that Mrs A could be suffering from mental illness and that this could have been impacting on Mr A's mental health.
7.3.6	Surrey Police had no recorded reports of domestic abuse between Mrs A and Mr A on Surrey Police / National police systems.
7.3.7	According to neighbours, (in statements made to the police after the event), they had started to see changes in Mrs A's appearance (frail and a little unkempt) during the early part of 2015. No concerns were raised about the relationship between Mrs A and Mr A, although neighbours had noticed Mr A becoming more agitated regarding Mrs A's memory loss.
7.3.8	Mr A's diary and a number of hand-written notes were seized at the home of Mr & Mrs A and have been included under Section 6 for clarity.
	Lessons learnt
7.3.9	Surrey Police identified from the ICAD (log of initial command and deployment) that when the police responded to the report from the neighbour on 15 June 2015, the attending officers were not made aware that Mr A was a registered firearms holder prior to forcing entry. This raised concerns about officer safety and the general public.
7.3.10	Surrey Police also have identified that they need to consider other members of the household when reviewing licence holders especially if there are concerns around mental health.
	Actions
7.3.11	It has been recognised that checks of the police system should have been made by the Force Control Room prior to police deployment. All staff have been de-briefed and the learning from this incident will be used in future training.

7.3.12	The Head of Contact Management will review the current technical issues that prevent a quick cross-check across two systems which would enable the Contact Centre to more easily identify if there is a registered firearms holder at an address.
7.3.13	If during the security visit, the Licensing Enquiry Officer suspects either the firearms licence applicant or someone co-residing in the property, suffers from a mental-health-related illness this should be reflected in the police letter to the applicant's GP requesting specific confirmation of suitability.
7.4	**Medical Practice R**
7.4.1	Dr F was the dedicated GP for Mrs A. Dr F stated that Mrs A suffered from rheumatoid arthritis and was under the care of the Rheumatology Department at East Surrey Hospital. Mrs A also suffered from hypertension but was not depressed.
7.4.2	Dr F confirmed that Mr A always accompanied Mrs A and was very supportive. Dr F was aware of Mr A's hearing problems and said he spoke in a loud voice to Mr A and he felt that Mr A understood the conversations.
7.4.3	On 30 March 2015 Mrs A had blood tests taken, following presentation to Dr F stating memory loss. On 6 May 2015 Mrs A met with Dr F to review blood tests and was diagnosed with atrial fibrillation. She was prescribed Apixaban and Bisoprolol and was also referred to the Community Mental Health Team. Dr F met with Mrs A on 8 and 26 May and 9 June 2015 to review her medication.
7.4.4	On 10 June 2015 Mr A spoke to Dr G, concerned that Mrs A was taking a lower dose of her medicine than prescribed. Dr G phoned Mrs A and reinforced that she must take the correct dosage.
7.4.5	Mr A was assigned to Dr H until 10 April 2015 and then to Dr G. Mr A had only presented once in the past 5 years, for an infected insect bite, when he saw another doctor in the practice. There were no other health issues identified by the doctors apart from Mr A's hearing problems.
7.4.6	A fellow member of the gun club recalls seeing Mr A being on two sticks in the last year as he had arthritis but there are no supporting medical records.
7.4.7	Dr F confirmed that the practice had received a letter from the police in 2012 relating to the renewal of the firearms licence for Mr A. At that time the practice had no reason to flag concerns about issuing the licence. The practice confirmed that they do not normally keep such letters on the patient's file but on this occasion the letter was retained.

7.4.8	**Lessons learnt:** None identified by the Medical Practice.
7.4.9	**Actions:** None identified by the Medical Practice
7.5	**Surrey County Council Adult Social Care Service**
7.5.1	Surrey County Council confirmed that they had no contact with either Mrs A or Mr A .
7.6	**Surrey & Borders Partnership NHS Foundation Trust (SaBP)**
7.6.1	Mrs A was referred to SaBP on 13 May 2015 by Dr F following concerns expressed by Mr A that his wife (Mrs A) appeared to be experiencing short term memory problems. The multidisciplinary team discussed the referral the following day.
7.6.2	A plan was developed as follows: • Follow up appointment offered with Community Mental Health Team for Older People (CMHT OP) Nurse on 20 August 2015 • Referral for CT scan (made for 15 June 2015, the date of the death of Mrs A and Mr A.) • Out-patient appointment to be offered by Consultant on receipt of CT scan results. • Appointment letter and CT referral form completed and sent on 14.May 2015.
7.6.3	Following the death of Mrs A, SaBP commenced a Serious Incident Requiring Investigation (SIRA) as required by NHS England Serious Incident Framework 2013.
7.6.4	**Lessons learnt:** SaBP carried out all its necessary procedures within their agreed timetable.
7.6.5	**Actions:** A SIRA is being carried out.
7.7	**Surrey and Sussex Healthcare NHS Trust (SSHT)**
7.7.1	Dr F referred Mrs A to a private Rheumatology clinic at SSHT in March 2012; Mrs A had intravascular injections of Kalalog for her rheumatoid arthritis and wanted to explore biological treatments.
7.7.2	Mrs A was reviewed by a medical consultant on referral and subsequently transferred to a specialist clinic. Mrs A had one more medical review by the team registrar in September 2013.
7.7.3	Between March 2012 and June 2015, Mrs A was seen a total of nine times in the Rheumatology department. Mrs A responded well to the treatment and spoke of going on a golfing holiday in February with Mr A.

7.7.4	Following Mrs A's death she was taken to the mortuary at SSHT.
7.7.5	SSHT also made the following comments: • Mrs A appeared to be a very positive person and was always well dressed • There was no knowledge of her potential memory loss • There were no concerns raised about domestic violence within her relationship with Mr A.
7.7.6	Mr A had one contact with SSHT to obtain test results for his hearing loss.
	Lessons learnt
7.7.7	SSHT was not aware that there could have been changes in Mrs A's mental health. Although all staff are required to participate in Safeguarding training, SSHT are considering how staff in Out-patients can enquire more fully about patients' general wellbeing.
7.7.8	A second consideration by SSHT relates to how they share information with other agencies, including GP practices, so that they are fully apprised of the overall health issues of a patient and therefore better able to explore appropriate support that can be given.
	Actions
7.7.9	Safeguarding Training will be updated to include enquiries about the general wellbeing of a patient and the highlighting of possible domestic abuse issues.
7.7.10	A review of how information is gathered, documented and shared with other health professionals in order to support the wider wellbeing of a patient especially in Out Patients.
7.8	**First Community Health and Care**
7.8.1	Mrs A was not known to First Community Health and Care.
7.8.2	Mr A attended the Audiology department on 17 October 2012. A senior Audiologist replaced a broken loop on Mr A's hearing aid. Other checks were made to the ear tube and all was correct.
7.8.3	**Lessons learnt:** None identified.
7.9	**Spire Gatwick Park Hospital**
7.9.1	Spire Gatwick Park Hospital confirmed that they had an appointment booked for Mrs A on 15 June 2015 for a CT scan as booked by SaBP. Mrs A did not attend - this was the date of her death.
7.9.2	**Lessons learnt:** None identified.

7.10	**Reigate & Banstead Borough Council**
7.10.1	Reigate and Banstead Borough Council confirmed that they had no contact with either Mrs A or Mr A other than through Council Tax and the Electoral Roll.
7.10.2	**Lessons learnt:** None identified.
7.10.3	**Actions:** None identified.
7.11	**Voluntary Organisations**
7.11.1	The Independent Chair liaised with local voluntary support groups as below, who provided helpful information. They had no direct engagement with Mrs or Mr A and so an IMR was not appropriate.
7.11.2	Age Concern Merstham, Redhill and Reigate (ACMRR) confirmed that there is support in the area for carers who are older people and people with mental health issues, although much of the provision / support is only made available following diagnosis of dementia which had yet to take place for Mrs A. ACMRR also confirmed that their key role was to support older people; if an older person's mental health declined then they would refer to other agencies as below.
7.11.3	East Surrey Alzheimer's Society (ESAS) supports people with mental health issues and their carers in the community. Referrals are received from the Community Mental Health Team (CMHT) via their doctor. In this case, Mrs A had not had a formal diagnosis and therefore had not been referred to the services of ESAS.
7.11.4	ESAS highlighted that they have Dementia Navigators who provide a highly responsive, individualised information and signposting service to people with dementia, their immediate carers, families and friends. There is an assigned Navigator for the area where Mrs A and Mr A lived. However once again, referral was reliant on Mrs A being diagnosed with dementia.
7.11.5	Both organisations stated that more could be provided for older people with mental health issues and for carers and in particular that there needed to be better co-ordination of publicity and targeted awareness-raising campaigns of the services available.

7.11.6	ESCCG also clarified that once Mrs A had a confirmed diagnosis of dementia, a multi-disciplinary health meeting would be established to identify Mrs A's needs and Mr A's needs as her carer. A risk assessment would be carried out to develop a plan of care based around Mrs and Mr A's family circumstances.
8.	**ANALYSIS**
8.1	This analysis is based on information provided in the IMRs. Where relevant this includes an assessment of comments upon the appropriateness of actions taken (or not taken), and offers recommendations to ensure lessons are learnt by relevant agencies. The Chair and Panel are keen to emphasise that these comments and recommendations are made with the benefit of hindsight.
8.2	Evidence from Mr A's letters and diary shows that, since early 2015, he had become progressively concerned about Mrs A's memory loss and her erratic behaviour. This appears to have escalated in May 2015 when his comments become increasingly desperate. Mrs A had reported this issue to her GP Dr F in March 2015 although evidence would appear to show that Mr A prompted this.
8.3	Dr F had referred Mrs A to the relevant service to be assessed for her mental health but no diagnosis had been made at the time of death
8.4	Mr A's diary entries express his concerns about Mrs A and also his mounting feelings of inability to cope. This appears to be practical (increased washing and remembering the medication for Mrs A), emotional (*"The last 3 months have been the worst of my whole life")* and his lack of ability to deal with issues due to his hearing impairment such as contacting a plumber ("*I need a plumber. Can't hear.*") The diary entries were made alongside everyday issues such as the date for a car service, what shopping was needed and the work he carried out at the farm.
	Could the event have been predicted and therefore avoided?
8.5	There is no evidence of previous domestic abuse by Mr A against Mrs A. There is some evidence from the diary and comments by family and neighbours that Mr A was struggling to cope as a carer with the worsening health of Mrs A.

8.6	Neighbours had suggested to Mr A that he should seek help but entries in his diary and notes highlight that he was unaware where to get this support from. The family have also indicated that perhaps neither Mrs A nor Mr A would want people in their own home. Mrs A and Mr A cared for Mrs A's mother until her death as they did not want anyone else, including agencies, in the home and the family also felt this would be the case for Mrs A although Mr A's diary entries suggest otherwise.
8.7	Drs F and G did not identify any concerns about Mrs A's welfare or about Mr A's wellbeing and ability to cope as a carer. It is not clear whether Mr A was asked about any support that he may need but his diary implies this was not the case**.** It is also unclear whether Mr A had disclosed the full extent of Mrs A's physical deterioration in terms of her incontinence and
	incoherent comments.
8.8	It should be highlighted that no formal diagnosis of memory loss or dementia had taken place at this stage. Once this had happened the expectation is that a multi-disciplinary team would have reviewed the care needs of Mrs A and Mr A.
8.9	Mr A's phone call to Medical Practice R in June with concerns about Mrs A not taking the appropriate medication might have identified the risk of a carer struggling to cope with the behaviour of his partner.
	Were there any barriers experienced by Mrs A, the victim or her family / friends colleagues in seeking support from professional service providers?
8.10	Mrs A was regularly seen by her own GP and was in the process of receiving a diagnosis about her memory loss. Mrs A was also seen for her Rheumatoid arthritis by SASH every three to six months. As already stated Mr A had a hearing problem, which sometimes left him feeling isolated.
8.11	Although no formal diagnosis of memory loss had been made it is apparent that Mr A was struggling with the situation and according to his diary needed help.

8.12	Mr A regularly attended Mrs A's GP appointments and it was noted that Mr A was always supportive of his wife. As stated above, it is not clear whether the GP offered any services to Mrs A or Mr A whilst awaiting her follow up referral. Mr A stated in his diary on 29 May that he had expressed to the GP that he "*could cope with everyday problems or I could cope with* [redacted] *but the 2 together was too much of a strain. I'm the weak link"* followed by *"No comment".* This was not noted in the Medical Practice IMR and so no GP feedback is available.
8.13	Research and interviews with ACMRR and ESAS has shown that there are good services in the local area to support older people and people with mental health issues but better signposting and information sharing about these services may have assisted Mr A.
	Were there opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim or any mental health issues that should have been referred to specialist health professionals or domestic abuse support service that were missed?
8.14	Mrs A regularly visited SASH every three to six months. Staff at SASH have mandatory adult safeguarding training although this case has highlighted that there needs to be better awareness of the general wellbeing of a patient especially in Outpatients. Mrs A appears to have
	been very open and talkative on her visits to SASH, often mentioning her love of golf, and there could have been opportunities to enquire about wider general health issues.
8.15	Evidence from the local GPs does not indicate whether there were any concerns about domestic abuse. It is also not known whether the GPs have training or knowledge about the services available around domestic abuse.
8.16	There was an identified lack of opportunity for Mrs A to speak privately to a health professional in the last few months of her life as she was always accompanied to her appointments by Mr A. An individual conversation would have allowed Mrs A the opportunity to share any private concerns she may have had, including if there had been any concerns about domestic abuse.
	Were there any opportunities for agency intervention or support regarding Mr A, the perpetrator, which were missed?

8.17	Mr A attended all Mrs A's appointments with Dr F who was also aware that Mr A had a hearing problem. From evidence obtained it is unclear whether there was any enquiry by Dr F into Mr A's ability to cope and his mental health, but his diary implies this was not the case**.** An individual conversation with Mr A would have allowed him the opportunity to flag up his concerns about Mrs A's more intimate problems such as incontinence and his increasing inability to cope. It is not known whether Mr A's family were aware of the extent of Mrs A's deteriorating health such as her incontinence and Mr A's increasing desperation.
	Given the use of a licensed firearm in the case, was the licensing of the firearms relating to Mr A rigorous enough and could anything further have been done to reduce the risk of the incident occurring?
8.18	Surrey Police were responsible for renewing Mr A's firearms licence which he had held since 1980 (prior to that it was renewed by Leicestershire Constabulary). His last licence was renewed in 2012 and was processed by Surrey Police Firearms Department in accordance with the Firearms Law Guidance to the Police 2002.
8.19	Mr A fully complied with all conditions in the guidance; as his firearms licence was for sport and recreation and he was a full member of a gun club. Mr A confirmed he had no medical problems when submitting the forms. His renewal form was signed by the required number of referees, who stated that they saw no reason not to renew for Mr A's licence. One of the referees held a senior position in his local gun club as required by the Guidance.
8.20	In 2012, the Firearms Licencing Enquiry Officer carried out the requisite
	security check by visiting Mr A's home. All the firearms were stored correctly in a gun cabinet in a bedroom and there were no police concerns at that time about Mr A holding a firearms and gun licence.
8.21	A letter was sent by Surrey Police to Mr A's GP who had no medical concerns at that time about Mr A holding a firearms licence. There was no marker entered onto his patient record to note that he was a gun holder which would have assisted if Mr A's increasing anxiety about his role as a carer had been identified. The surgery's usual practice is for such letters to be destroyed, although on this occasion it had been retained.
8.22	The Home Office has updated its guidance to make it clear that GPs need to alert the police to any concerns they may have regarding their patient's suitability to be licensed, and that this is an ongoing obligation throughout the currency of the certificate. (See Appendix 2 for further information).

8.23	Surrey Police advise that automated searches occur daily on a licence holder's name. Addresses linked to firearms incidents are checked manually to see if relating to a licensed firearms holder place of residence.
	Is domestic abuse in relationships between older people considered?
8.24	National research[1] identifies that little consideration has been given to the scope and nature of domestic abuse within the older population. There are a number of current factors which may contribute to this lack of knowledge such as social and cultural barriers to disclosure and the failure of professionals and organisations to recognise or consider domestic abuse when occurring in older people. There is also confusion over the distinction between domestic abuse and elder abuse, which may mean the needs of this group are overlooked altogether.[2]
8.25	Safeguarding Adult data in Surrey indicates that 22% of safeguarding referrals for over 65s (23% across England) were initiated because of alleged abuse committed by a partner or family member.
8.26	Surrey's Joint Strategic Needs Assessment (JSNA) has identified older people as a specific risk group and that identified triggers domestic abuse in older people include: • poor long term relationships, • a carer's inability to provide the level of care required, • a carer with a mental or physical health problem who feels under stress with the caring relationship.
8.27	As already noted in this report, Mrs and Mr A were very private people and

[1] Exploring service responses to domestic abuse in later life - Dr Julie McGarry, Christine Simpson and Kathryn Hinsliff-Smith , Nottingham University
[2] Older Women and Domestic Violence – A report for Help the Aged by Imogen Blood

	may not have chosen to divulge any issues to professionals. The diary of Mr A discloses his concerns about his own inabilities to cope practically and emotionally with the decline in Mrs A's mental and physical health and her increasing needs. This appears to have been exacerbated by his challenges with his hearing impairment, which may have impacted on his ability or desire to seek help. As noted, there are no previous reports or concerns raised of domestic abuse within Mr A and Mrs A's relationship, but Mr A's diary identifies two of the triggers as described in paragraph 8.26 which could lead to domestic abuse in older people.
8.28	SASH has identified in its action plan that it will be including domestic abuse in its safeguarding training and this report recommends that other agencies do likewise and that the training should specifically include the consideration of domestic abuse in older people.
	Are there any training or awareness-raising requirements to ensure a greater knowledge and understanding of domestic abuse processes and services?
8.29	IMRs from the health agencies show that Adult Safeguarding training is carried out but the extent of inclusion of domestic abuse (especially in older people) is not identified. Safeguarding Adults training is available to GPs and a recommendation relating to their compliance with NICE Guidelines has been identified.[3]
	Has there been appropriate consideration given to any equality and diversity issues that appear pertinent to the victim, perpetrator *e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race religion and belief, sex and sexual orientation and including isolation due to hearing impairment.*
8.30	Mrs A and Mr A were both white British and in their late 70s. Age has been considered in this report; older people may become more isolated either through circumstances or choice. Questions to consider are: *i) Do older people have access to appropriate information and support?* *ii) Is the information in an accessible format for older people?*
8.3	Mr A appeared to have felt isolated due to his hearing impairment which compounded his feelings of desperation. It appears that there was no mention of support for Mr A in coping with his role as a carer, despite being an older person himself

[3] Domestic violence and abuse; how health service, social care and the organisations they work with can respond effectively" February 2014

9	**LESSONS LEARNT FROM THE REVIEW**
9.1	It has been difficult to engage with local GPs in this domestic homicide review; their involvement being limited to factual information with no lessons identified to be learnt from.
9.2	There has been difficulty in obtaining timely information from various agencies due to unknown contacts and lack of secure emails.
9.3	This case involved older people with friends / colleagues who were also older. On a number of occasions, when contacting an acquaintance, the person had since deceased. This caused distress to the living relative.
9.4	There was no sharing of information between agencies for example between the GPs and SASH where Mrs A was being treated for rheumatoid arthritis.
9.5	There seems to have been no consideration by the GPs of the needs of Mr A, who felt isolated by his hearing impairment and was struggling in his role of becoming the carer for Mrs A.
9.6	Although support services for older people with mental health issues and those experiencing domestic abuse are available, better signposting and active promotion in an accessible format should be considered.
9.7	Some GP practices appear to have a recording system for patients who possess firearms but Medical Practice R do not use such a system. The Practice has a protocol to destroy the police firearms notification letter but on this occasion it was retained on Mr A's file. This will not comply with good practice as identified by the new Home Office guidance on the issuing of firearms licences.
10	**CONCLUSIONS**
10.1	There is no evidence of any previous domestic abuse within Mr & Mrs A's relationship but the Panel is mindful that this cannot be ruled out with certainty. It has been difficult to compile information on their relationship as Mrs A and Mr A have no children and Mrs A had no siblings or close relatives. The couple had different social interests (golf and gun clubs) and appeared to have been very private people.
10.2	The review has identified ways in which support, advice and practice could be improved by health services including GP practices, to ensure the "whole picture" of a person presenting with memory impairment is reviewed, including the impact on the carer. This is more pertinent when the people involved are older or have a disability.
10.3	Older people can become isolated through circumstances or through choice. In this case it appears the carer was not coping with the situation but was unaware of how to gain help.
10.4	There are services available to support older people who may be struggling to cope as carers or if experiencing domestic abuse but there is a need for better co-ordination and more accessible information to support the community in general and especially GPs in signposting. There is a willingness of the voluntary sector to work with agencies to review their services to ensure they meet the needs of older people and especially those with mental health and carer responsibilities.
10.5	Surrey Police appear to have correctly carried out their processes for firearms certificates in compliance with Home Office regulations but they are amending their procedure to take into account the wider family situation where possible e.g. changes in health circumstance of those living in the house.
10.6	The DHR panel also believes that the procedures between the Police and GP practices when issuing Firearms Licences should be improved. Information sharing should be more robust especially when changes in the mental health of a licence holder or a person residing at the same address are identified during the timespan of the licence.

11.	RECOMMENDATIONS
11.1	**Recommendation 1 - Surrey Health and Wellbeing Board** **1.1** To increase health professionals' awareness (including GPs) of the Surrey Safeguarding Adults Board and Surrey Safeguarding Children Board Domestic Abuse priorities and especially those relating to older people. This should include consideration of the main triggers for domestic abuse in older people; poor long-term relationships, a carer's inability to provide the level of care required, a carer with a mental or physical health problem who feels under stress with the caring relationship. **1.2** To increase awareness and encourage participation by GPs in the IMR and Domestic Abuse training provided by organisations such as local Safeguarding Boards. **1.3** To encourage all health and safeguarding professionals to undertake training on routine enquiry about domestic abuse in line with the NICE guidance "Domestic violence and abuse; how health service, social care and the organisations they work with can respond effectively" *(February 2014).*
11.2	**Recommendation 2 - NHS England, Surrey and Sussex Teams** **2.1** To implement good practice guidelines for GPs on their participation in DHRs, including the requirement of The Care Act, section six which states that partners must co-operate and share information **2.2** To reinforce that Primary Care including GP practices should participate in relevant DHR training as provided by organisations such as Surrey Safeguarding Adults Board.
11.3	**Recommendation 3 - Surrey Domestic Abuse Development Group** **3.1** To reinforce that all professionals need to review the "whole" family situation, especially in older people when changes in health needs could lead to increased risk of domestic abuse. This should include the needs of the carer, especially if the carer is an older person. **3.2** To remind all professionals to ensure that when a patient is always accompanied by a carer that there is the opportunity for separate consultations with the patient and with the carer in order to provide the space to divulge any confidential issues including domestic abuse

11.4	**Recommendation 4 - For all District, Borough and Surrey County Councils** **4.1** In partnership with other agencies, including voluntary and faith sectors, to continue to develop and enhance provision and accessible information for older people relating to support for mental health issues and for carers. **4.2** To expand the distribution of this information to a wider range of facilities frequented by older people e.g. golf clubs, bowls clubs, day centres.
11.5	**Recommendation 5 - East Surrey Community Safety Partnership** **5.1** To recommend to the Home Office that it should implement recommendation 11 within the HMIC report "Target the Risk", namely: *Immediately, and with a view to implementation within 18 months, the Home Office should ensure that the current proposals for the sharing of medical information between medical professionals and the police for the purpose of firearms licensing, allow the police effectively to discharge their duty to assess the medical suitability of an applicant for a Section 1 firearms or shotgun certificate.* This should have due regard to ensuring the system: i. Does not allow licensing to take place without a current medical report from the applicant's GP, obtained and paid for by the applicant in advance of an application for the granting or renewal of a certificate, and which meets requirements prescribed by law;
	ii. Is supported by a process whereby GPs are required, during the currency of a certificate, to notify the police of any changes to the medical circumstances (including mental health) of the certificate holder which are relevant to the police assessment of suitability for such a certificate, and within which the certificate holder is statutorily required to notify the police of any such changes.
	It is noted that a new firearms licensing system was implemented in April 2016[4] to improve information sharing between GPs and the police and reduce the risk of future tragedies.
11.6	**Recommendation 6 - East Surrey Community Safety Partnership** **6.1** To recommend to the Home Office that it considers reducing the period for a firearms licence renewal from five years to three years, particularly in older people, which will ensure a more frequent medical review report to the police.

12.	**INDIVIDUAL AGENCY ACTIONS AS IDENTIFIED WITHIN THE SUBMITTED IMRs**
12.1	**Surrey Police**
12.1.1	That the Force Control Room checks police systems for Firearm certificate
	holders within a household prior to police deployment. This will be
	reinforced in future training.
12.1.2	That the Head of Contact Management should review the current technical
	issues with the GUCCI / Intergraph interface as soon as practicable, to
	ensure a quicker check for the Contact Centre that there is a registered
	firearms holder at an address.
12.1.3	That if, during the security visit, the Licensing Enquiry Officer suspects
	either the firearms licence applicant or someone co-residing in the
	property, suffers from a mental health related illness this, should be
	reflected in the police letter to the applicant's GP requesting specific
	confirmation of suitability.
12.2	**Surrey & Sussex Health Trust (SASH)**
12.2.1	That Safeguarding Training will be updated to include a focus on the
	overall wellbeing of a patient and to highlight exploration of any potential
	domestic abuse issues.
12.2.2	That a review is carried out of how information is gathered, documented

[4] Home Office Guide on Firearms Licensing Law 2016

and shared with other health professionals in order to support the wider wellbeing of a patient especially in Outpatients.

APPENDIX 1

REIGATE AND BANSTEAD DHR PANEL TERMS OF REFERENCE (Agreed September 2015)

The purpose of the Domestic Homicide Review Panel is to:

1. Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
2. Seek to establish whether the event could have been predicted and therefore avoided.
3. Liaise closely with the Coroner's office throughout the process and ensure the DHR helps to inform the inquest.
4. 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 or those with a mental illness.
5. 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.
6. Identify what needs to change in order to reduce the risk of such tragedies happening in the future and improve service responses for all domestic violence victims through improved intra and inter-agency working.
7. In addition the following areas will be addressed in the Individual Management Reviews and the Overview Report:
    - Whether there were any barriers experienced by Mrs A, the victim or her family / friends / colleagues in seeking support from professional service providers.
    - Whether there were opportunities for professionals to routinely enquire as to any domestic abuse experienced by Mrs A or any mental health issues that should have been referred to specialist health professionals or domestic abuse support services that were missed.
    - Whether there were opportunities for agency intervention or support regarding Adult MP, the perpetrator, which were missed.
    - Given the use of a licenced firearm in the case, was the licensing of firearms relating to Mr A rigorous enough and could anything further have been done to reduce the risk of the incident occurring.
    - The consideration of Domestic Abuse in relationships between older people

8. The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services.
9. The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator e.g. age, disability (including isolation due to hearing impairment), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
10. The review will consider any other information that is found to be relevant. Where information emerges that disciplinary action should be taken, this will follow separate internal agency procedures.

Independent Chair: Liz Borthwick 21.09.15

APPENDIX 2

HOME OFFICE GUIDANCE ON FIREARMS LICENSING

The Home Office Guidance on Firearms Law 2002 was revised in 2014 (and again in 2015) following a number of significant events including the tragic shooting in Durham in January 2012 whereby a registered firearms holder fatally shot and injured three family members before shooting himself.

A national report[5] which reviewed the Home Office Guidance on Firearms Law 2012 (revised in 2015) identified that GPs were not obliged to respond to the police request for information and that such information should not in itself result in a refusal of an application for a firearms. It was noted by this report that the police were not obliged to make any contact with an applicant's GP unless prompted to do so by disclosure of a medical condition after a firearms certificate has been issued. The GP was not obliged to respond.

Subsequently a new firearms licensing system came into effect on 1 April 2016[6]. It has the approval of the British Medical Association, Police forces, shooting organisations and the Information Commissioner's Office.

Under the new structure:

- A new firearms application form has been introduced, which makes clear to applicants that information about their health will be shared between GPs and the police.
- GPs are now required to place an 'encoded reminder' on a patient's record when issued with a firearm licence, to flag up this status on visiting the surgery. GPs will be able to inform the police licensing department if the patient's health deteriorates during the validity of the firearm licence.
- New guidance has been published to help GPs and the police operate the new system. Responsibility for deciding if a person is suitable to hold a firearm certificate remains with the police.
- Further improvements are planned in late 2016 to ensure that every applicant's GP will be contacted by the police before issue of the firearm licence.

This is progress; however, the report states that there are concerns that if this requirement on GPs is not legally binding, its effectiveness relies solely upon their co-operation.

[5] HMIC Report Target the Risk
[6] HO Guide on Firearms Licensing Law April 2016

APPENDIX 3

HOME OFFICE QUALITY ASSURANCE PANEL RESPONSE TO FIRST DRAFT

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Louise Round
Chief Executive
Tandridge District Council

5 April 2016

Dear Ms Round,

Thank you for submitting the Domestic Homicide Review report for East Surrey to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 24 February 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded the report did not sufficiently probe the key elements of the case, such as dementia, caring responsibilities, memory loss and disability. There is little known about the victim in the review, although the Panel accepts this was due to no direct family engagement in the review process. However, the Panel suggested that it may have helped the review if colleagues and employers were contacted. In addition, the Panel suggested that the input of voluntary sector specialists, such as Age Concern and a charity that understands memory loss, may have helped draw out equality and diversity issues in the review and could assist in seeing the dynamics of the relationship through a different lens.

There were other aspects of the report which the Panel felt could be revised, which you may wish to consider:

- Please ensure the narrative in the overview report and executive summary is aligned. For example, the executive summary states that the inquest has not yet concluded, but the overview report does not;
- It would be helpful to clarify which family members and friends were met by the chair and whether the information in the review is from face-to-face interviews or other sources, such as police files;
- Please note the redactions can be uncovered by copying and pasting into a blank document.

The Panel would be grateful for a revised report by 5 May that takes account of the feedback they have provided. It would be helpful if you could mark the revisions you make in the report when it is resubmitted.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel