Domestic Homicide Review
Executive Summary

Safer North Hampshire Community Safety Partnership

Report into the murder of Alice (Adult F)

May 2014

Author – Shonagh Dillon (3rd Author)

December 2018

Contents

1. Glossary

CPR - Cardiopulmonary Resuscitation

CSP – Community Safety Partnership

DA – Domestic Abuse

DVA – Domestic Violence and Abuse

DHR – Domestic Homicide Review

IMR – Independent Management Review

The independent author of this report, the DHR panel members and Safer North Hampshire Community Safety Partnership wish to offer their deepest condolences to everyone who was affected by Alice's death.

2. The Review Process

This summary outlines the process undertaken by Safer North Hampshire Community Safety Partnership domestic homicide review panel in reviewing the homicide of Alice, who was a resident in their area.

The following pseudonyms* have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

Name*	**Sex**	**Age at time of Murder**	**Relationship with victim**	**Ethnicity**
Alice	Female	79	Victim	White UK
David	Male	58 (at time of the incident)	Son and Perpetrator	White UK
Lucy	Female	Unknown	Daughter in law	White UK
Mark	Male	Unknown	Son	White UK

Criminal proceedings were completed in October 2014 and the perpetrator pleaded guilty to murder. He was sentenced to life imprisonment with a minimum sentence of 12 years to be served.

The decision to undertake a DHR was made by Safer Hart Community Safety Partnership (CSP) in May 2014 and the Home Office was subsequently informed.

The review considered agency contact with Alice and the perpetrator, David, her son, from May 1st 2012 – May 31st 2014. This time frame was agreed to be appropriate by all original panel members in July 2014.

3. Contributors to the Review

Following the decision to conduct this DHR, agencies were requested to return Summaries of Involvement to help the panel understand what, if any, contact agencies had with Alice and David during the specified period of review. Having considered the Summaries of Involvement, it was decided to request the following Individual Management Review (IMRs):

a. Frimley Park NHS Hospital Foundation Trust
b. North East Hampshire and Farnham Clinical Commissioning Group on behalf of Primary Care.

All IMR authors and Panel members were independent of any direct contact with the subjects of this DHR. None were the immediate line managers of anyone who had had direct contact.

4. The Review Panel Members

The DHR panel consisted of the following agencies:

Job Title	Agency
Community Safety Manager	Safer North Hampshire (2nd Author)
Head of Serious Case Reviews	Hampshire Constabulary
Head of Safeguarding	Hampshire County Council – Adult Services
Joint Chief Executive and Chair of Hart Community Safety Partnership (at time of incident)	Hart District Council
Portfolio Holder for Community Safety (at the time of the incident)	Hart District Council
Chair	North East Hampshire Domestic Abuse Forum
Partnerships Manager	North East Hampshire and Farnham Clinical Commissioning Group
Consultant Nurse	North East Hampshire and Farnham Clinical Commissioning Group
Partnerships Manager	Purple Futures Community Rehabilitation Company
Community Safety Officer	Safer North Hampshire
Coordinator	The Hartley Wintney Voluntary Care Group and Hartley Wintney and District over 55s Forum

The CSP commissioned the first independent author of this report to commence the review in July 2014 and there were a total of three meetings held. These were:

- 24th July 2014
- 26th September 2014
- 16th June 2015

The relationship between the first chair/ author and the CSP broke down in 2015

The second author of the report was the Community Safety Manager and the Home Office raised concerns about the impartiality of this author and the report submitted. The decision was made to commission a third author to the report, Shonagh Dillon, on October 4th 2018.

5. Author of the Overview Report

The author of this report, Shonagh Dillon, was independent of all agencies involved in the panel having been commissioned sometime after the initial panel meetings she had no dealings with the initial inquiries and no contact or knowledge of the family members. She is also independent of the two previous author's and chairs and did not sit on the panel.

Shonagh Dillon is a Home Office accredited DHR chair and has over two decades in the violence against women sector supporting victims and survivors of domestic abuse, sexual violence and stalking.

6. Summary of the Chronology/ Case

Alice was a 79 year old retired divorcee when she died. She was living in a privately-owned house in Hart, Hampshire. Alice had two sons, one of which lived with her and had done so for approximately 20 years. Alice's ex-husband had been deceased for many years and there is no history of domestic abuse relevant to this case.

David was 58 years old at the time of this incident and working part time as an exercise instructor locally.

There is limited information on Alice's contact with others on the lead up to her death, although we do know from witness statements that Alice had few friends and little social life. It is known that she was last seen by someone other than David, two days prior to her death. This individual has been identified as an elderly friend of Alice who declined involvement in this review process.

Alice last spoke to her second son Mark two days before her death when she told him that she was upset following an argument with David over use of the telephone.

On the morning of the murder, David was booked to teach a Pilates class at a local health club at 10.30 am. David telephoned the club stating that he would not be attending as he had 'something to sort out'. He was seen walking his dog between 10.30 and 10.45 am by the local postman. At 10.44 am police received a call from Lucy, Mark's wife, stating that David had called her and disclosed that he had 'strangled mother', and David had asked if Mark and Lucy would take care of his dog.

Police arrived at the home address of Alice and David at 10.55 am and found a set of keys outside the front door. On entry to the property, police found Alice laying on the floor; she was pale and had no detectable pulse. The Ambulance service were called and the attending officer began CPR.

At this point, David returned to the property and was arrested on suspicion of attempted murder.

Paramedics attended the house and took Alice to Frimley Park Hospital where continued efforts were made to save her life. Alice did not regain consciousness and was later pronounced dead.

A Home Office Pathologist later examined Alice and found her to have died from brain injury caused by pressure to her neck. There were no other injuries reported.

David was subsequently charged with the murder of Alice and remanded in custody.

Alice

We know very little about Alice as a person but the little bits of information we do have about Alice from witness statements can give us some indication of who she was as a person. Alice loved to garden, she spent hours cultivating her plants and took great pride in them, she adored her dog and would walk him daily. She also had a passion for wildlife. Alice had five siblings and four weeks prior to her death one of her sisters had passed away

Although this only gives us a very small picture of who Alice was, it is important that her presence is not lost to us.

The Perpetrator

David was a single man residing in a bungalow that he jointly owned and occupied with his mother, Alice. He was a self-employed Pilates and yoga instructor who worked 12 hours per week at leisure facilities close to his home address.

David told police that he had no friends, that it was just him, his dog and his mum. David further stated that in the weeks leading to his mother's death, they had had limited social interaction, each choosing to speak to the dog but not to each other.

7. Key Issues arising from the Review

Although there is little to no information from statutory agencies in respect of Alice or David there is were some key issues the author and panel concentrated on with regards to this case, these were:

- Coercive and Controlling behaviour
- Older people and domestic abuse

8. Conclusions

The third author concentrated on the information provided in the police interviews with David and undertook some interviews with staff from his place of work.

Subsequent to the arrest of his mother's murder the situation David describes in his interview with police and confirmed by Mark his brother was that Alice and David had argued about Alice's use of the landline phone. David wanted Alice to use a mobile phone rather than the landline to call her family and friends and Alice, by all accounts, found the use of a mobile difficult. Given Alice's age and her obvious

isolation it is unsurprising that using the mobile would have been something alien to her. She may also have felt that this was a prescriptive measure given that we know she contributed to half of all the bills in the house and paid her way in equal measure to David financially.

Although there is no evidence of financial control from David from the information made available to the author, it is noteworthy that David felt the need to control Alice's use of contact with the outside world by prescribing to her that she use the mobile instead of the landline.

From the information available we know that Alice and David argued about this factor and this resulted in Alice not wanting to speak on the phone to anyone and hanging up on people who did call her. Being unable to speak to any of her friends or other family members we do not know Alice's feelings around this, but it can be inferred that this left Alice further isolated from contact with the outside world and cut off from communicating in a way she was comfortable with.

Isolation is a common factor used by perpetrators in domestic abuse relationships. It is apparent that Alice lived a solitary life and although she did regularly see one friend at least once a week we also know that her contact with others was via her use of the landline.

Given Alice's age in relation to her lack of familiarity with technology it would be entirely appropriate for David to concede that using a mobile phone was proving difficult for her and that this was cutting her off from contact with people she cared about, particularly at a time that she was grieving for her sister. It is therefore fair and proportionate to assert that David's behaviour and his insistence that Alice use a mobile was unreasonable. Whether this constitutes a pattern of coercion remains unknown but it is certainly evidence of controlling behaviour.

At the time the panel convened there was less information available about older people and DA. The national charity SafeLives have recently put a "spotlight" on Elder Abuse and highlighted the need for us to respond to older people in a different way. They found that older people experience domestic abuse for twice as long as those under 61 and they are also far less likely to access services[1]. If domestic abuse was a continuous feature in Alice's life this may have pointed to why agencies had no knowledge of her.

It is also worth noting in the SafeLives report that 44% of the perpetrators of older people are adult family members, 73% experience coercive and controlling behaviour and there is a 'systematic invisibility' of older victims of DA due to their differing needs[2].

[1] http://www.safelives.org.uk/spotlight-1-older-people-and-domestic-abuse
[2] http://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf p.5, 11 & 12

9. Recommendations

The third author and the panel took time to consider the elements of coercive control and elderly abuse in the analysis of this case. The panel felt it important, given the passage of time and the introduction of new legislation and research into both these areas that consideration is given to these elements for future victims and survivors of domestic abuse in the Safer North Hampshire area.

Single Agency Recommendations

6.1 The author felt that given the analysis of the report the bulk of recommendations would remain within a multi-agency context. No single agency was aware of any abuse.

Multi-Agency Recommendations

6.2 Address the information, training and multi-agency response health professionals could utilise, e.g. routine screening, to respond to potential victims of DVA.

6.3 Multi-agency response to elder abuse and the intersectionality of DVA and age in the context of domestic abuse, particularly from adult male sons.

6.4 Raise awareness to multi-agency partners of vulnerable adults in relation to DVA and in the context of social isolation.

6.5 Make accessible via training and awareness raising the understanding of Coercive Control, particularly in the context of the subsequent legislation.

National Recommendations

Governmental driver to raise the issue of elder abuse and Domestic Homicide. Utilising the most recent research available. Namely - *Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK – Hannah Bows (2018)*[3].

[3] https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcy108/5211414

10. Appendix A – Letter from the Home Office

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

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

Caroline Ryan
Community Safety Manager
Safer North Hampshire

27 October 2017

Dear Ms Ryan,

Thank you for submitting the Domestic Homicide Review (DHR) report for Hampshire to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 20 September 2017. I apologise for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel was grateful for the information on the delays in submitting this report and the challenges in getting it completed. However, the Panel was concerned that there is insufficient probing and little professional curiosity considered in the report. At only 13 pages, the report felt rushed, lacks detail and is light on analysis.

While there was no domestic abuse identified by the review, it would be helpful if the report could articulate that the dynamics of this behaviour were considered as part of the analysis. More specifically, the review describes the fact that the perpetrator and victim lived private lives, but there is no examination of whether coercive control and isolation were factors in this case.

You mention that there was a breakdown in relationship between the panel and chair which meant the DHR process had to be taken back to its early stages. The Panel would welcome further detail on what contributed to the difficult relationship. The statutory guidance recognises that disputes between review panel members can be healthy and form the basis of rigorous challenge, but they need to be resolved by the review panel and chair. If they cannot be resolved, the DHR report should record the areas of disagreement and actions taken towards a resolution.

There were also some other aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- The review does not examine why the victim had no contact with agencies other than her GP and whether there were any barriers to reporting, which the Panel felt were critical to this review;
- There were issues around flagging, referrals and adult safeguarding procedures but these have not been adequately explored. This should also examine whether existing policies and procedures remain effective;
- The absence of contributions from the victim's family and friends gives the victim a limited voice in the report;
- The Panel thought it may have been helpful to interview the perpetrator's work colleagues;
- There is no examination of whether the victim discussed home life with her other son. Additionally it would help if the review could clarify why the victim's other son would not engage with the DHR process;
- No action plan or executive summary was submitted with the report. The Panel would normally expect to see three separate documents as in the templates set out in the statutory guidance;
- It may have been helpful to have engaged a domestic abuse specialist on the review panel;
- There is no information on the independence of the original chair or the second appointed author;
- Pseudonyms would have made the narrative easier to follow and would help humanise the review;
- The precise date of the homicide should be removed to enhance anonymity;
- The Panel questioned the relevance of part one and part two in the report;
- Please spell out acronyms in full the first time they are used;
- The report needs a full proof read as there are a number of typing errors.

The Panel would be grateful if you could provide a revised version of the report with the changes suggested, together with confirmation of your publication intentions, by 15 December 2017. Please clearly indicate where changes have been made in the revised report, and make it clear in the subject line of your email when resubmitting that the documents contained are revised versions for reconsideration. Please let me know if this will prove difficult.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel

Appendix B - Domestic Homicide Review Terms of Reference for AK

This Domestic Homicide Review is being completed to consider agency involvement with **Alice** and her son, **David**, following her death in **May 2014**. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with **Alice** and **David** during the relevant period of time: **May 1st 2012 – May 31st 2014.**

3. To summarise agency involvement prior to **May 2014**.

4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

7. To commission a suitably experienced and independent person to:

   a) chair the Domestic Homicide Review Panel;
   b) co-ordinate the review process;

c) quality assure the approach and challenge agencies where necessary; and
d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

9. On completion present the full report to the Home Office Domestic Homicide Review Panel and local Community Safety Partnership.

Membership

10. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Your agency representative must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.

11. The following agencies are to be involved:
    a) Clinical Commissioning Groups (formerly known as Primary Care Trusts)
    b) General Practitioner for the victim and perpetrator
    c) Local domestic violence specialist service provider e.g. IDVA
    d) Education services
    e) Children's services
    f) Adult services
    g) Health Authorities
    h) Substance misuse services
    i) Housing services
    j) Local Authority
    k) Local Mental Health Trust
    l) Police (Borough Commander or representative, Critical Incident Advisory Team officer, Family Liaison Officer and the Senior Investigating Officer)
    m) Prison Service

n) Probation Service
o) Victim Support (including Homicide case worker)

12. Where the need for an independent expert arises, for example, a representative from a specialist BME women's organisation, the chair will liaise with and if appropriate ask the organisation to join the panel.

13. If there are other investigations or inquests into the death, the panel will agree to either:
    a) run the review in parallel to the other investigations, or
    b) conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Collating evidence

14. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

15. Each agency must provide a chronology of their involvement with the **Alice** and **David** during the relevant time period.

16. Each agency is to prepare an Individual Management Review (IMR), which:
    a) sets out the facts of their involvement with **Alice** and/or **David**;
    b) critically analyses the service they provided in line with the specific terms of reference;
    c) identifies any recommendations for practice or policy in relation to their agency, and
    d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

17. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought **Alice** or **David** in contact with their agency.

Analysis of findings

18. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
    a) Analyse the communication, procedures and discussions, which took place between agencies.
    b) Analyse the co-operation between different agencies involved with the victim, perpetrator, and wider family.
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations access to specialist domestic abuse agencies.
    f) Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and perpetrator's family

19. Sensitively involve the family of **Alice** in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the perpetrator's family who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.

20. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

21. Coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.

Development of an action plan

22. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.

23. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

Media handling

24. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

25. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

26. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

27. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

28. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

Disclosure

29. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise

and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.