Annex 1

Ceredigion Community Safety Partnership

Domestic Homicide Review - Executive Summary

'Betty'

Died: May 2019

Review & Investigation

Paul Johnston – Independent Chair and report Author
August 2021 (Signed-off by CSP October 2021)
Finalised December 2023

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1. INTRODUCTION

1.1 This summary outlines the process undertaken by the Ceredigion Community Safety Partnership (CSP) domestic homicide review panel in reviewing the death of Betty in May 2019. She was unlawfully killed by her husband John at their home in the Ceredigion area of Wales.

1.2 The names Betty and John are pseudonyms. They have been used protect their true identities and those of their family members. Betty who was white British, was in her late 70's at the time of her death and John was in his early 80's. John is also white British. Betty and John had been married for nearly 60-years. They were English but had moved to Wales upon their retirement from work. They had no children.

1.3 A forensic post-mortem examination of Betty revealed evidence of the onset of Alzheimer's disease. Although no formal diagnosis was ever made (or there was ever a need to conduct assessments under the Mental Health Act or the Mental Capacity Act), the indications are that the disease may well have been the cause of what many people described as Betty's uncharacteristic behaviour at times. It needs to be clearly stated at the outset of this executive summary that in making the point about the effects of Alzheimer's disease, the review panel is not seeking to apportion blame upon Betty for what happened, nor does it condone John's actions.

1.4 In December 2019, John pleaded guilty to Betty's manslaughter. He was sentenced to three-years and four-months imprisonment. In sentencing him, the Judge said, *"The simple fact here,* [John], *is that you killed your wife. It was no mercy killing - you killed her because you snapped...You snapped because, in your words, the red mist came down and, on your account, she either deliberately or accidentally knocked your glasses off...You throttled her with both hands with such force that she died. She must have been terrified as you throttled her, unable to fight you off or get you to stop".*

1.5 In line with agreed protocols, the police notified the CSP of the circumstances of Betty's death because she had been unlawfully killed by her husband. The CSP subsequently commissioned the review which began in January 2020 and concluded in May 2021. The review panel met in person in January and March 2020 and thereafter, due to Covid-19, four meetings were held via a video conferencing platform, interspersed with numerous telephone and email exchanges.

2. CONTRIBUTORS TO THE REVIEW

2.1 Nine agencies were contacted to establish whether they had been involved with Betty and/or John and of those, only the following two confirmed they had. They were asked to seal their records:

- *Dyfed-Powys Police*
- *Hywel Dda University Health Board (Primary Care Services).*

2.2 Both agencies submitted Individual Management Reviews. Their report authors were independent in that they had no previous involvement with Betty or John or any line-management responsibility for staff who had been involved with them.

2.3 John participated in the review and was interviewed twice, once in prison and then again upon his release. Two of Betty and John's neighbours also took part as did two of Betty's long-standing friends. Also interviewed was Betty and John's solicitor.

2.4 The review Chair wrote to Betty's two sisters and her brother asking if they would be willing to participate in the review. One of Betty's siblings replied, saying that because they had not been in contact with Betty for over 20 years, they felt unable to contribute.

2.5 The CSP appointed Paul Johnston to undertake the roles of Independent Chair and overview report Author for the review. He is an independent practitioner who has chaired and written numerous domestic homicide reviews, child serious case reviews, adult safeguarding reviews and multi-agency public protection arrangement serious case reviews. He has a wealth of safeguarding and multi-agency working experience and has enhanced knowledge of domestic violence and abuse issues including so-called 'honour'-based violence, research, guidance and legislation relating to adults and children. He is also a former chair of Multi-agency Public Protection Arrangements (MAPPA). He has completed all the Home Office sponsored domestic homicide review training and together with a colleague, he also delivers independent domestic homicide review training. He retired from an English police service in 2005 as head of homicide and major crime investigation and since then has been involved in supporting the families of homicide victims in Northern Ireland. He is a University Associate Lecturer in policing and acts as an End Point Assessor for the Police Constable Degree Apprenticeship programme. He was judged to have the necessary independence, experience and skills for the task.

2.6 During the review, the following representatives participated in meetings and discussions, all of whom were independent in that they had not previously been involved with Betty or with John.

Name	Organisation
Review and Investigation Limited	
Paul Johnston	Chair and report Author
Ceredigion County Council	
Sue Darnbrook	Statutory Director
Diana Davies	Corporate Manager Partnerships and Performance
Naomi McDonagh	Partnerships Manager
Donna Pritchard	Corporate Lead Officer Porth Ceredigion
Judi O'Rourke	Service Manager Adult Services
John Forbes Jones	Corporate Manager Mental Wellbeing
Dyfed-Powys Police	
DCI Anthony Evans	Detective Chief Inspector (SIO)
Temp Supt. Steve Davies	Temporary Superintendent
DI Gary Williams	Detective Inspector
DCI Gareth Roberts	Detective Chief Inspector
National Probation Service	
Hannah Williams	Interim Senior Operational Support Manager
Christine Harley	Head of Dyfed Powys Local Delivery Unit
West Wales Domestic Abuse Service	
Michelle Pooley	Chief Executive
Hywel Dda University Health Board	
Mandy Nichols-Davies	Head of Safeguarding
Dr Sion James	General Practitioner, Tregaron Surgery and Deputy Medical Director, Primary Care and Community Services
Dyfed Drug and Alcohol Service	
Sian Roberts	Service Manager
Mid and West Wales Fire and Rescue Service	
William Bowen	Home Fire Safety Manager
VAWDASV (advisory role)	
Natalie Hancock	VAWDASV Regional Adviser Mid and West Wales

3. SCOPE AND TERMS OF REFERENCE FOR THE REVIEW

3.1 The review examined agency involvement with Betty and with John between 1st November 2017 and the date of Betty's death in May 2019. (November 2017 was when Betty and John first divulged to a professional (their solicitor) that they were experiencing difficulties in their relationship).

3.2 The Terms of reference for the review were set to determine whether:

- *The incident in which Betty died was an isolated incident and whether there were any warning signs that might have been identified by agencies*
- *More could be done locally to raise awareness of services available to victims of domestic abuse, especially for older people*
- *There were any barriers experienced by Betty and John or their family/friends/colleagues in reporting any abuse, including whether they knew how to report domestic abuse, should they have wanted to*
- *There were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Betty and John that were missed*
- *There were opportunities for agency intervention in relation to domestic abuse regarding Betty and John that were missed*
- *Alcohol abuse was a factor in the relationship between Betty and John, whether agencies knew about it and if so, what was or could have been done to intervene*
- *Anyone considered Betty to have been at risk of harm and whether those concerns were shared and acted upon.*

4. REVIEW SUMMARY CHRONOLOGY

4.1 On the day before Betty died, Betty and John had an argument. John left the house and drove to see a friend who lived in England. He told the friend that Betty had been shouting at him and had been throwing objects around the home and that he was afraid he would have done something 'nasty' had he stayed there. The friend offered John a bed for the night, but John declined, saying he needed to get home to look after Betty.

4.2 Early the following morning, when Betty and John were in the bedroom, another argument broke out between them. John later described to the police how Betty had been shouting and that she had knocked his spectacles off, breaking them. He said to the police, *"It just all kicked off, I just lost it, I just had enough, I couldn't see the light at the end of the tunnel."* He told the police that he had grabbed Betty around her neck and had shaken her to make her see sense. He added that when Betty did not move after he had released his grip, he thought, *"Good God, I have done something bad. I've killed her, haven't I?"* He then telephoned 999 and told the call handler that he thought he had killed his wife.

4.3 John was arrested and he admitted that he had strangled Betty. The subsequent police investigation revealed no known history that John had previously been violent or abusive towards Betty. Instead, a picture emerged of a couple who had been very happily married until about three-years before Betty's death. Around that time, long-term close friends of theirs in England had noticed a dramatic change in Betty, so much so that they questioned privately whether she may be mentally unwell. The friends said that Betty would be perfectly fine one minute and then suddenly and for no apparent reason, she would *'fly off the handle'* and become abusive, rude and vitriolic. They added that such behaviour was completely out of character and that after a while, Betty would revert to her normal self and act as if nothing had happened.

4.4 Friends and neighbours of Betty and John in Wales said very much the same thing. They described John as being a placid, mild-mannered and friendly person who was very easy to get along with. They added that Betty tended to be quite reclusive and that sometimes they could hear her shouting and using bad language at John, which was often followed by the sound of doors slamming. They also said that Betty could be the most charming and kind person at times, but that for no apparent reason she would change and become distant, rude and dismissive.

4.5 The neighbours said that in the months leading up to Betty's death, John's physical health had notably deteriorated; he had lost weight and he looked exhausted. They said that for several weeks John had been sleeping in his car or in bed and breakfast accommodation because Betty (in his words) *"Had just lost it",* and he wanted to diffuse the situation. One of the neighbours offered to let John use an empty house they owned, but he declined, saying he had to be there for Betty because he loved her and that he was really worried about her. They all thought that Betty was mentally unwell and they encouraged John to seek medical help on her behalf.

4.6 John went to see his doctor in the hope of securing some support for Betty, but he was told that unless Betty herself accepted there was something wrong, there was nothing that could be done. Just under a year before Betty died, in June 2018, John telephoned what he thought was a mental health helpline (but he had inadvertently telephoned a police non-emergency number). He said that he and Betty had been having relationship difficulties for two years, but matters had escalated over the past few months. He added that Betty had been smashing things and going into fits of rage. John went on to say that he and Betty had been married for fifty years, but recently she had accused him of never having loved her. He added that he couldn't do anything right as far as Betty was concerned.

4.7 When the police arrived, John told them that he and Betty had been enjoying the day, but that Betty had become emotional after he had declined to sit down with her to listen to some classical music. She had reacted by saying that he no longer showed her any affection and that he didn't love her anymore, before becoming aggressive and smashing some crockery. Betty told the officers that she was fine and that there was no need for the police to be there. They offered to take Betty to hospital, but she declined, so they then asked Betty if she would be prepared to be visited by a Community Psychiatric Nurse (CPN). Betty agreed and then she wrapped her arms around herself and said that all she wanted was to be held by John.

4.8 The Community Psychiatric Nurse told the review that she attended Betty and John's home and that Betty had said that she and John had been married for a long time and that their relationship was okay, but that John did not show her much affection. The CPN added that there was no sign of Betty having a severe or enduring mental illness and that she did not want any help.

4.9 The review discovered that two days later Betty telephoned the Community Health Council (CHC) advocacy service and left voicemail messages saying she had told a CPN and the police that she was okay, but she had now changed her mind and she needed immediate help. The CHC telephoned Betty back and obtained her consent to notify her GP about her calls. They then telephoned the GP Practice Manager and sent an email saying Betty required immediate help and that she had said she was being aggressive with her husband and was drinking all day, but she did not know why.

4.10 After the weekend, the CHC telephoned the practice to ask what had happened. The practice manager said he had telephoned the crisis team and that they in turn would contact the CPN. The Practice Manager said he would chase it up after a few weeks. The CHC then telephoned Betty to suggest she make an appointment with her GP and Betty said she would. Betty did make an appointment (which took place only four-days after her telephone calls to the CHC) when she told her GP that she wanted her husband to cuddle her and that he never discussed anything in life and avoided arguments. She said she had been drinking more and that she blamed it on John. Crucially, an entry that had been made in Betty's patient record about her interaction with CHC was missed by the GP, so there was no discussion with Betty about her plea for help with her aggression towards John (nor was she referred to support services in respect of her alcohol use).

4.11 John had a consultation with the same GP on the same day. He said Betty was verbally and physically aggressive towards him and that she 'smashed things', but that she had not hit him. He added that he had called the police, but that Betty had declined counselling. He told the GP that for about the last three years, Betty had been verbally aggressive, that she had been complaining that he did not cuddle her, that it had become much worse recently and that as a result he had been sleeping in his car. The GP referred John to the Local Primary Mental Health Service (LPMHS) for counselling. The referral letter stated that John had said that Betty picked on him constantly and that he was now a quivering wreck and that during recent quite severe arguments, she had been throwing things around the house and the police had been called.

4.12 Betty saw a different GP in November 2018 and the medical notes indicate the consultation was specifically about her stress and anxiety at home. They stated, *'Have had some relationship difficulties but easing now'*. This GP also missed the entry about Betty previously asking for help with her excessive drinking and her aggression towards John.

4.13 A month later, John had a consultation with the Practice Nurse during which he said Betty was being abusive at times and was smashing things. He said there was no specific trigger for her behaviour and that it had started three years previously and that it was getting worse. John added that he and Betty had argued prior to the appointment that day over opening a tin. It was noted that John was frustrated because Betty wouldn't go for help and that he couldn't get help for her. The Practice Nurse briefly discussed the issue with the Safeguarding Lead GP who advised that John should self-refer to Relate.

4.14 Later that month (December 2018), John also had a consultation with a GP during which he said Betty had been violent and angry for the last two weeks or so. It was recorded that he said Betty could *'Blow up with neighbours'* and that she had declined counselling. John was noted to be '*Very cross at lack of support'.*

4.15 It was less than six-months later that John strangled Betty.

5. KEY ISSUES ARISING FROM THE REVIEW

5.1 John told the review Chair that during the two years leading up to Betty's death, he was at his *'Wit's end'* and that he didn't know what to do or where to turn to. He is adamant that he was never the victim of domestic abuse from Betty and that she was simply a woman who through no fault of her own and through illness sometimes acted out of character and that because he was her husband, it was inevitable that he would bear the brunt of it. He added that to this day he still doesn't really know happened, but that he was the only person to blame. He does however feel that *'The system'* had let Betty down because she was clearly not well, and no-one was able to do anything to help her. Those sentiments are shared by Betty and John's friends and neighbours who highlight that John really did try to get help for Betty, but none could be provided either because Betty was unaware of how she was behaving or if she was conscious of it, she didn't acknowledge it. None of them (including John) were aware prior to this review, that Betty had tried to track-down the Community Psychiatric Nurse or that she had told the CHC that she was being aggressive towards John, that she was drinking all day, that she required immediate help and that she had consented for her GP to be told about it.

5.2 A key issue for the review therefore was to address the lack of awareness (and information sharing within the GP practice) about domestic abuse and the need to conduct targeted 'Ask and Act' enquiry where appropriate. (None was made in respect of Betty or John and the practice say they had not been aware at the time of what support services were available locally for victims or perpetrators of domestic abuse.

5.3 Another key issue identified during the review was the need for awareness raising about domestic abuse services that are available for older people in the region and the avenues through which the services may be accessed. Specifically, the review panel acknowledged the need to raise awareness about what constitutes coercive and controlling behaviour and how, particularly an older person may recognise they are being subjected to it. There was also an identified need to emphasise that domestic abuse is not gender specific, that it is prevalent in every community and that it affects people of all ages. It was identified that professionals can have an underlying presumption that domestic abuse doesn't happen to older people and as such, they then don't ask about it. Ageist attitudes towards older people can contribute towards domestic abuse not being accurately identified by professionals, and it was acknowledged that practitioners should not stereotype or make judgments in relation to older people and that they explore all potential experiences of older people in transparent and open-minded ways.

6. MAIN CONCLUSIONS

6.1 From a clinical perspective, the GP practice had no reason to question Betty's cognitive function and there was nothing to suggest that she did not have capacity to make her own decisions. Although John was frustrated that Betty would not accept support, the practice simply could not impose any intervention upon her. This dilemma is nothing new to practitioners: Betty was an independent adult who had the right to autonomy in her own decision-making. That said, the Practice clearly missed opportunities to support Betty (and John), especially after the communications from the CHC, but also after various disclosures were made to them by both Betty and John.

6.2 The review panel is of the view that neither the police, the community mental health nurse or the CHC missed opportunities to intervene in relation to domestic abuse between Betty and John. Any indications that abuse might have been taking place were at a very low level and presented John potentially as being the victim and Betty the perpetrator, with the thresholds for referrals to other agencies significantly short of being met. No one ever envisaged, nor could they have done, that John would be likely to assault Betty, let alone that he would cause her death through an act of violence.

6.3 The Older People's Commissioner for Wales 'State of the Nation' - An overview of growing older in Wales (2019) publication argues that to stop the abuse of older people, professionals and wider society need to be more aware of abuse of older people, that older people at risk of or experiencing abuse should be able to access support services, older people who experience abuse should have access to legal justice with accountability for those who abuse and that incidences of abuse of older people should be prevented. It also identifies that currently there is no single dataset that provides a complete picture of the scale and type of abuse experienced by older people in Wales.

6.4 There are, however, ongoing initiatives that are aiming to close the gap in support provision for older people in the region, for example, in April 2020, the Older People's Commissioner for Wales established an action group of organisations who are working together to ensure that older people can get the support they need to keep them safe and protected from abuse and crime. As part of the work, they have produced leaflets which provide information to help people recognise the signs of abuse and the different forms it can take, what people can do if they are concerned about someone else, and where they can go for help and support. In addition, the HOPE Project (Helping others participate and engage), a partnership project between Age Cymru, Age Cymru's local partners and Age Connects Wales partners is now delivering advocacy for older people (50+) and carers across Wales. A recommendation from the review is that the Community Safety Partnership will maintain contact with the initiatives to ensure they are fully exploited in the region.

7. AGENCY KEY LESSONS LEARNED

7.1 Everyone involved in the review appreciated how crucial it is that organisations consider issues around domestic abuse and older people at a strategic level and in partnership arrangements and of the need to increase coordination between primary care, safeguarding and domestic abuse services in acknowledgement that care and dependency issues are often intertwined.

7.2 There was also an acknowledgement of the need to target older people with specific materials and messaging about domestic abuse and not assume they are aware of the services available to them. Being aware that older people may be less likely to disclose abuse and ensuring that professionals are able to ask appropriate questions and give potential victims the space and opportunity to talk were also key lessons learned.

7.3 It was noted that the Regional Partnership are working with survivors across the region to build upon survivor engagement and a communication framework with the intention of engaging with all communities across Mid and West Wales and to use it to inform and improve practice and service design.

7.4 It became clear during the review of the need for Primary Care to identify how they can support improved uptake in safeguarding and domestic abuse training and monitor compliance with it. The Health Board have been supported over the last three-years by the Safeguarding and Access to Justice Lead in the Older Person's Commissioners Office in the rolling out specific training on domestic abuse and older people, but the value of IRIS training to GP practices needs to be re-emphasised.

8. RECOMMENDATIONS

8.1 CEREDIGION COUNTY COUNCIL

8.2

- *That the VAWDASV specific working group that is being established in Ceredigion during the Autumn of 2021 investigate the opportunities for resourcing an older people's specific domestic abuse service or resourcing one through Dewis Choice/WWDAS*

- *That the Regional VAWDASV Commissioning Sub-Group, within development of the Regional VAWDASV Service Specification, maximises opportunities presented by ongoing initiatives that are aimed at closing the gap in support provision for older people in the region, for example, the Older People's Commissioner for Wales action group of organisations and the HOPE Project*
- *That the Regional VAWDASV Communication and Engagement Subgroup and VAWDASV's survivor Engagement and communication framework, considers the merits of establishing a focus group of older person service users to examine issues around domestic abuse awareness raising and access to services.*

8.3 DYFED-POWYS POLICE

8.4

- *That Dyfed Powys Police engage in training around specific older victims of VAWDASV and that they share and encourage all officers to access the online DHR learning materials available, including older victims and rurality sessions.*

8.5 HYWEL DDA UNIVERSITY HEALTH BOARD

8.6

- *Hywel Dda University Health Board should share and promote the Regional thematic training materials in response to domestic homicides, including that on rurality*

- *That the Carmarthenshire IRIS I pilot is fully evaluated with a view to scaling it up for use in Ceredigion*

- *GP practices should be provided with resources (including the VAWDASV Regional Pathway to Support Document for GPs) to signpost victims and perpetrators of domestic abuse*

- *A single point of access in Primary Care should be identified to co-ordinate the distribution and implementation of resources*

- *The value of IRIS training needs to be re-emphasised and the proposals to implement pilots of IRIS in GP clusters should be renewed together with a review of ways of addressing any funding gaps. Should funding remain a*

barrier, the Welsh Government and the Home Office should be notified accordingly

- *GPs and the Practice Nurse at Betty and John's GP Practice should attend Level 2 adult safeguarding training and all its practitioners should complete 'Ask and Act' training. Compliance should be monitored within Primary Care and reported to the UHB Strategic Safeguarding Working Group*

- *The GP Practice safeguarding policy should be updated to describe presentations that should be considered as possible indicators of domestic abuse and which therefore present opportunities for the GP to make triggered enquiries*

- *Processes should be put in place at the GP Practice to ensure that any messages received about domestic abuse are immediately notified to the doctor on call and that the information is recorded on patients' records*

- *Similar messaging should take place across all GP practices in the county for consistency*

- *The UHB should highlight the fact that the safeguarding matrices in the All-Wales Clinical Governance Self-Assessment Tool (CGPSAT) are outdated and require review.*

END OF DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY