Executive summary report of the Domestic Homicide Review into the murder of Mary in September 2018

Under s9 of the Domestic Violence Crime and Victims Act 2004

Independent Chair: Deborah Klée

Independent report Author: Deborah Klée

December 2019

Contents

	Page
1.0 Review process	3
2.0 Contributors to the review	5
3.0 Terms of reference for the review	6
4.0 Summary chronology	8
5.0 Key issues arising from the review	9
6.0 Conclusions	12
7.0 Recommendations from the review	15

1.0 The review process

1.1 This summary outlines the process undertaken by Norfolk County Community Partnership domestic homicide review panel in reviewing the homicide of Mary who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim and perpetrator to protect their identities and those of their family members.

Name	**Age at the time of the domestic homicide**	**Relationship**
Mary	76	Victim
Henry	81	Perpetrator

1.3 Criminal proceedings were completed in December 2020 and the perpetrator was detained in hospital under Section 37 of the Mental Health Act.

1.4 The process began with an initial meeting of the Norfolk County Community Partnership in January 2019 when the decision to hold a Domestic Homicide Review (DHR) was agreed. All agencies that potentially had contact with Mary and Henry prior to the point of death were contacted and asked to confirm whether they had been involved with them.

1.5 The following agencies were contacted to check their involvement with Mary and Henry:

- Norfolk Police
- East of England Ambulance Service
- Social housing provider for the couple
- Norfolk County Council Adult Social Care services
- Norfolk Safeguarding Adult Board
- GP Medical Practice for the couple
- Leeway Domestic Violence & Abuse Services
- Local authority in which the couple resided
- Norfolk & Suffolk Relate
- Norfolk Sexual Assault Referral Centre
- Sue Lambert Trust
- Norfolk and Waveney Clinical Commissioning Group
- Norfolk and Norwich University Hospitals NHS Trust
- Norfolk and Suffolk NHS Foundation Trust.

1.6 Six of these agencies provided chronological accounts of their contact with Mary and Henry. Norfolk County Council Adult Social Care services and Norfolk Adult Safeguarding had no record of contact with either Mary or Henry and therefore

they were not asked to provide a chronology. Leeway Community Services and Norfolk and Waveney CCG had no direct involvement and likewise, were not asked to provide a chronology.

1.7 The family liaison officer requested a meeting on behalf of the report writer, with Mary and Henry's son and daughter. The NHS Serious Incident (SI) report writer agreed to join the DHR report writer for this meeting, as meeting with the family is also part of the SI process. The meeting took place on 4th March 2019. The son and daughter were offered advocacy and support services by the family liaison officer, namely Advocacy After Fatal Domestic Abuse (AAFDA), and Victim Support Homicide Service (VSHS), but declined.

1.8 Mary and Henry's daughter provided contact details of other family members and friends who were willing to talk to the DHR report writer about her parents and the lives they lived prior to the fatal stabbing.

1.9 The DHR report writer interviewed:

- Mary and Henry's two adult children
- Mary's sister
- Henry's youngest brother
- Henry's friend of twenty-five years.

1.10 The DHR covered in detail the period from July 2014, when Henry first raised concerns with his GP regarding his loss of memory, to September 2018, when Mary was murdered. However, agencies were invited to provide additional historical context where appropriate.

1.11 The chronologies were brought together to provide an integrated chronology of events.

1.12 The integrated chronology was reviewed by the DHR Panel and it was agreed that Independent Management Reviews (IMRs) would be requested from the following agencies:

- Norfolk Police
- Social housing provider for the couple
- GP Medical Practice for the couple
- Norfolk and Norwich University Hospitals NHS Trust
- Norfolk and Suffolk NHS Foundation Trust.

1.13 The Overview Report Writer provided guidance for the IMR authors on writing an IMR, in line with Home Office guidance (Home Office 2016). The IMR writers were not directly involved with Mary or Henry, neither were they line manager for any member of staff involved in the case. IMR reports were quality assured by a senior accountable manager.

2.0 Contributors to the review

DHR Panel members

2.1 Panel members did not have direct contact with Mary or Henry, with the exception of the couple's GP of many years. The Panel felt that the GP's contribution to the panel discussion was invaluable and it was agreed that Gary Woodward from the CCG would co-write the IMR from the Medical Practice to ensure independence.

Name	Position/organisation
Tabatha Breame	Domestic Abuse Change Co-ordinator, Children's Services, Norfolk County Council
Saranna Burgess	Head of Patient Safety and Safeguarding, Norfolk and Suffolk Foundation NHS Trust
Angela Freeman	Project Support Officer, Public Health, Norfolk County Council
Kim Goodby	Norfolk and Norwich University Hospitals NHS Trust
Service manager	Quality and Patient Safety Lead, for the couple's Clinical Commissiong Group (CCG)
Meadhbh Hall	Adult Safeguarding Nurse, Norfolk and Waveney CCGs
Service manager	Head of service, local registered provider of social housing
Margaret Hill	Community Services Manager, Leeway Domestic Violence & Abuse Services
Deborah Klée	DHR Panel Independent Chair and Overview Report Writer
Walter Lloyd-Smith	Manager, Norfolk Safeguarding Adults Board
Stuart Morton	Head of Integrated Care, Adult Social Care Services, Norfolk County Council.
Amanda Murr	Senior Policy and Research Officer, Office of the Police and Crime Commissioner for Norfolk
Service manager	Head of Early Help for the couple's Local Authority area
Dr. Kelly Semper	Advanced Public Health Officer, Norfolk County Council
Jon Shalom	NCCSP Manager, Public Health, Norfolk County Council
Karen Taylor	Admin Support Adult Safeguarding Team, Norfolk and Waveney CCGs
GP	Medical Practice for the couple
Gary Woodward	Adult Safeguarding Lead Nurse, Norfolk and Waveney CCGs
Detective Inspector Alix Wright	Norfolk Police MASH

DHR Panel Chair and Author

2.2 Deborah Klée was appointed as Independent Chair and Overview Report Writer by NCCSP. Deborah has not worked for any of the organisations involved in this review.

2.3 Deborah has chaired a number of Safeguarding Adults boards. As an independent consultant Deborah has experience of writing both DHR and Safeguarding Adult Review (SAR) overview reports. Deborah previously worked in senior positions at the Audit Commission and Healthcare Commission. Prior to this she worked for 20 years in the NHS as an occupational therapist and executive manager. www.deborahklee.org.uk

Deborah has extensive experience in the field of older people and elder abuse. She was the author of *Living well in later life: a review of progress against the national service framework for older people,* 2015, Healthcare Commission. She was Head of Strategy for Older People, Healthcare Commission; Interim Head of Policy, Help the Aged; Editor Working with Older People, Emerald Publishing. She has peer reviewed several papers on elder abuse for the Journal of Adult Protection.

3.0 Terms of reference

3.1 The terms of reference for this DHR were agreed by the Panel as set out below.

3.2 The review will:

3.2.1 Consider the life of the perpetrator, to seek to determine the relevance of any earlier incidents or events that could provide insight and contribute to a better understanding of the nature of domestic violence and abuse.

3.2.2 Draw up a chronology of events from July 2014, when Henry first raised concerns to his GP about his memory loss, to September 2018. All agencies involved in the life of the perpetrator will contribute to an integrated chronology, to determine where further information is necessary. Where this is the case, Individual Management Reviews (IMRs) will be requested from relevant agencies.

3.2.3 IMRs will cover the same time period as the chronology –July 2014 to September 2018. However, the IMR writer should use their discretion to include any relevant information outside of this time period. IMRs should analyse learning and report it under the following headings:

- **Professional curiosity** – how can we encourage and support appropriate curiosity with families, and between professionals?
- **Information sharing and forum / fora for discussion** – how can we ensure that we use opportunities for discussion effectively, include all relevant parties, act promptly and clearly; and share information well?

- **Collaborative working, decision making and planning** – how can we improve timely and collaborative planning and get strong and shared decisions?
- **Leadership: ownership, accountability and management grip** – how do we ensure effective leadership and champion better safeguarding, locating clear accountability?

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

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

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

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

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

3.2.8 This Domestic Homicide Review will be carried out alongside a Serious Incident (SI) review that is being conducted by South Norfolk Clinical Commissioning Group (CCG). The two processes will be co-ordinated to avoid any duplication, including interviews with the family and friends.

Family involvement

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

3.2.10 The DHR Panel will agree a communication strategy that keeps the family informed, if they so wish, throughout the process. The Panel will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

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

Practical Arrangements

3.3 It was decided that it would not be appropriate to interview Henry as he was being detained in a secure mental health unit and was not in a sound state of mind to contribute to the review, and further distress could be caused.

3.4 Family and friends were asked how they would prefer to contribute to the review; telephone conversation, email or a meeting with the report writer. All of the family and friends' requests were honoured including the involvement of spouses/partners, who made a valuable contribution to the review by sharing their own insights.

4.0 Summary chronology

4.1 At the time of her death Mary was 76 years of age. She was living in a rural Norfolk village with her husband Henry aged 81 years in a sheltered housing bungalow provided by a Registered Provider of social housing. Mary and Henry had been married for fifty years and had a son and daughter, both of whom lived in the locality.

4.2 Henry had become increasingly dependent upon Mary in recent years due to physical disability: a long history of severe back pain, osteoarthritis and chronic obstructive pulmonary disease, and in the four years prior to Mary's death, memory problems, anxiety and depression.

4.3 They were an independent couple and had managed without any care and support services, having declined any offers of help.

4.4 The couple were well known to their GP as they had both been patients with the same surgery for the past fifty years. When memory problems were first raised by Henry in 2014 the GP investigated and referred to the hospital's Memory Clinic. Mild cognitive impairment and anxiety were diagnosed at this time. This was treated with medication. In 2018 Henry's memory loss had increased and he was experiencing vivid dreams and hallucinations. As Henry was also presenting with Parkinsonian symptoms, a referral was again made to the Memory Clinic for investigations. At the time of the fatal stabbing the diagnostic process had not concluded, although Lewy Body Dementia[1] was considered the likely diagnosis.

4.5 The day before the fatal stabbing, the police received a call from Mary's neighbour. Henry had turned up at her address and was saying that he was frightened of being robbed. He had a large sum of money on him and told the neighbour that he had dementia, requesting her to ring the police on his behalf. A police officer arrived on the scene where Mary had now joined Henry. The money was locked up for safe keeping in the neighbour's gun cabinet and Henry and Mary were walked home by the officer. Henry had calmed down.

4.6 The following day, Henry stabbed Mary repeatedly in the head and neck with two long kitchen knives. A couple, who were neighbours, witnessed this, as Mary was trying to leave the house during the attack. They phoned for an ambulance.

[1] Lewy Body Dementia is a type of dementia that shares symptoms with both Parkinson's Disease and Alzheimer's Disease. Symptoms include fluctuating attention and alertness, visual and/or auditory hallucinations, delusions, mobility problems and sleep disturbance.

4.7 Henry continued to stab Mary, when the police arrived and tried to stab himself in the chest. The police shot Henry with an AEP (Attenuating Energy Projectile) to the stomach. This was the least lethal option to protect Henry, the police and bystanders.

4.8 Mary was lying in the doorway with no signs of life and severe wounds to her head and neck. She was pronounced dead at the scene. Henry was arrested for murder. A trial took place for Henry in December 2019, resulting in an order for his detention in hospital under section 37 of the Mental Health Act.

5.0 Key issues arising from the review

5.1 The key issues arising from this review are:

- Support for Mary as Henry's carer.
- Diagnosis of dementia and interventions
- Sharing of information.

Support for Mary as Henry's carer.

5.2 Mary's family believe that had she accepted professional help in caring for Henry then the fatal stabbing may have been prevented as professionals would have identified the increasing risk to Mary.

5.3 However, the GP had regular contact with the couple and despite careful monitoring could not have predicted Henry's sudden violent attack upon Mary. The GP saw Mary in the surgery without Henry in August 2018 and encouraged her to accept support in caring for her husband. The GP suggested referral to an Admiral nurse, but Mary declined.

5.4 Mary and Henry had always been self-sufficient as a couple. When Henry became increasingly dependent as a result of severe back pain and osteoarthritis, the couple continued to manage the situation without looking for, or accepting, any support or help.

5.5 In addition to being self-sufficient the couple were very private. They did not welcome strangers into their home. Family and friends stress that the couple would not have agreed to have anyone else come into the home to provide care for Henry. Henry had particularly strong views on this and Mary saw caring for Henry as her priority and her main role in life. Mary did not have a close friend which increased her isolation.

5.6 The social housing provider contacted the couple by telephone once a week, which was a valued part of the sheltered housing support. However, the couple did not make any further demands on the social housing provider. Support plans were agreed with Henry and Mary and the social housing provider updated these annually. Neither Henry nor Mary's support plans indicated that they needed any assistance.

5.7 Mary and Henry attended a luncheon club once a week organised by the social housing provider. Henry received Attendance allowance and Mary a Carer's allowance. They did not want any further help.

5.8 The services that had contact with the couple offered support to Mary in her role as a carer. The GP practice monitored the situation and kept the lines of communication open through consultations in the surgery, telephone conversations and two home visits. It is clear from the GP's records that the couple had a full and on-going dialogue with their GP regarding Henry's physical and mental health.

5.9 Although Mary and Henry were not open to accepting services and help, they did value and trust the care and support provided by their GP practice and their social housing provider. These were the only two organisations who had regular contact with the couple and could have potentially introduced information and/or services that they might have accepted. The GP did try to encourage Mary to accept support to care for Henry. However, given the couple's reluctance to accept help or have anyone other than close family in their home, an innovative personalised approach would have been required.

5.10 There was nothing more professionals could have done at that time, however there is some learning on how services might be planned and shaped differently to reach others like Mary living in small villages.

Diagnosis of dementia and interventions

5.11 When Henry raised concerns regarding his memory with his GP, the GP followed NICE guidance in investigating the cause of Henry's memory problems. The Memory Clinic diagnosed a mild cognitive impairment as a result of anxiety and depression. Henry was depressed as a result of his loss of independence due to physical disability. Although anti-depressants were suggested they were not prescribed by the memory service or the GP at this time. The GP discussed the use of anti-depressants with Henry, but Henry declined, and a note was made by the GP to revisit this intervention with Henry at a later date.

5.12 As a result of his deteriorating health, Henry had experienced several losses;

- His working life and role of provider when he retired in his forties as a result of back pain.
- He gave up his motorbike and sidecar and had to depend on Mary as a driver.
- His guns. Hunting was an important part of his life.
- The cottage that he had renovated.
- His vegetable plot.
- The hobbies and activities that he enjoyed.
- The death of his beloved dogs.

5.13 Talking therapy or other psychological interventions may have helped Henry to adjust to these losses and find a new purpose in life. However, it is unlikely that he would have accepted psychological support any more than he would have welcomed practical help outside of the family

5.14 The diagnostic process took time as the initial referral to the Memory Clinic in 2018 was declined and a referral made to the Movement Disorder Clinic to assess for Parkinson's disease as the symptoms are similar to Lewy Body Dementia.

5.15 On both occasions (for this key episode) when the referral was triaged by the specialist diagnostic service for dementia it was considered a routine referral with an expected wait of 28 days. There was nothing to indicate that the referral was more urgent.

5.16 The GP was asked by the DHR Panel what would have changed had Henry had an earlier diagnosis of Lewy Body Dementia. The GP said, 'Specific medication would have been prescribed, as well as a nursing support package (subject to the family's acceptance of diagnosis).'

5.17 The time period from concerns being raised by the family to the date of a diagnosis was four months. At the time of Mary's death an appointment date had not yet been confirmed. The triaging of these referrals was in keeping with Norfolk and Suffolk Foundation Trust (NSFT) policy.

Sharing of information

5.18 In general, organisations worked well together, sharing information in a timely and robust way. There are many examples of good practice, including the way health professionals met the NICE guidelines in the diagnostic process and treatment of Henry's symptoms. However, a smoother pathway for diagnosing dementia could be achieved, if there was a more integrated approach across the acute and mental health hospital trusts. Integrated physical and mental health clinics and electronic referrals could improve efficiency and outcomes for the patient.

5.19The exchange of information between the GP, NSFT and the Norwich and Norfolk University Hospitals NHS Trust (NNUH) was generally good.

5.20 The only exception to this is a discrepancy in relation to a fax sent on the 17th September 2018 to the NSFT from the NNUH on the clinical outcome and referral letter(s) following an appointment with the Movement and Disorder clinic at the acute hospital in July 2018. The chronology says that a letter was sent to the community psychiatric team on 27th July 2018 with this information, but there is no evidence that a fax was received by the mental health trust from the acute hospital any earlier than 17th September 2018.

5.21The NSFT IMR writer investigated this, as did the NNUH IMR writer. It was concluded through discussion by the DHR Panel that this could be due to an error in data entry or just an oversight. However, the missing fax resulted in a delay of 7 weeks. Prompt receipt of this referral could have sped up the diagnostic process and led to a timelier intervention. Opportunities for shared diagnostic clinics across the mental health and acute trusts were discussed by the DHR Panel. Also, the need for electronic records rather than fax for sharing of patient information across trusts. This is discussed further in lessons learned.

6.0 Conclusions

6.1 There is no conclusive evidence to suggest that Mary experienced domestic violence or abuse at any time in her relationship with Henry prior to her murder. However, family and friends describe elements of the couple's behaviour within their relationship that relate to traditional gender roles not uncommon in older people, but are now understood to be indicative of a level of coercion and control. Mary did not have a close friend which increased her isolation. A long history of medical conditions, with increasing carer dependency also led to stressors in the relationship. The couple had a good and close relationship with their GP, who was key to supporting Henry's diagnoses, and encouraged Mary to access support.

6.2 In general, organisations worked well together, sharing information in a timely and robust way. Only one example of a breakdown in communication across the wider health system was found which delayed investigations. The couple had a good relationship with their supported housing provider with regular contact, which would have enabled additional support to have been identified if needed. There are many examples of good practice, including the way health professionals met the NICE guidelines in the diagnostic process and treatment of Henry's symptoms. However, a smoother pathway for diagnosing dementia could be achieved, if there was a more integrated approach across the acute and mental health hospital trusts. Integrated physical and mental health clinics and electronic referrals could improve efficiency and outcomes for the patient.

6.3 This tragic incident occurred despite the offers of support from friends, family, health and housing professionals. Whilst there was no compelling evidence of domestic abuse in the couple's relationship prior to Mary's murder, it is clear that the additional burden of deteriorating mental and physical health had a significant impact on the couple's lives. Whilst agencies close to the couple did all that they could to offer support, more could have been done to ensure everyone was aware of these pressures, the potential for escalation in challenging behaviour and opportunities for their mitigation. This could have enabled safety planning, including de-escalation techniques, and consideration of other ways to support the individuals involved. However, Mary and Henry were a self-sufficient couple, wary of strangers and very private. Research tells us that this outlook is not uncommon in rural areas.

6.4 Norfolk has many rural communities where older people are caring for loved ones living with dementia. Innovative ways need to be found to reach people who might be in a similar situation to Mary. There are opportunities for Norfolk to further develop the Community Connectors approach, social prescribing and information and advice, to reach older people living in rural areas who might be resistant to traditional services. Working with organisations that have built a trusting relationship with people, such as housing associations and community and voluntary organisations, could make these services more accessible to this group of people.

Lessons learnt

6.5 The DHR Panel identified areas of learning to improve outcomes for people living with dementia and their carers. These have been grouped under the headings from Norfolk's thematic learning framework:

Professional curiosity

6.6 Norfolk County Council, Norfolk and Waveney CCGs and partners are working together to raise public awareness of dementia. These initiatives will continue with the aim of promoting early diagnosis and appropriate interventions.

- GPs in Norfolk are working to raise the awareness of dementia in their health checks. GPs currently reach approximately 24,000 40-74 year-olds per year with all those aged 60-74 receiving a specific dementia leaflet.
- The Healthy Aging campaign within Public Health includes raising the awareness of dementia.
- Information on dementia is included on the Norfolk County Council website.
- The Alzheimer's Society raises the awareness of dementia through Dementia Friends training and awareness raising events.

6.7 Mary did not at any time give any indication that she was experiencing domestic abuse or coercion and control. There was no reason for professional staff to delve deeper and it is likely that any probing would have alienated the couple from those services that they trusted. However, this review has highlighted the need to explore how older people living in rural areas can be reached in a way that is acceptable and meaningful for them.

6.8 Norfolk County Council is working in partnership with districts and health providers across Norfolk to improve the accessibility and reach of services to support people more appropriately, including those living in rural areas. This is being achieved through a Social Prescribing approach. Social Prescribing, sometimes referred to as "community referral", is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. This recognises that people's health is determined by a range of social, emotional and practical issues, so Social Prescribing seeks to address people's needs in a more holistic way. In South Norfolk, Community Connectors are now working from all GP surgeries as the link workers to deliver social prescribing, working with people to help them access local sources of support.

6.9 This personalised approach is ideal for reaching older people living in rural areas and people who experience domestic violence. Social Isolation/Life Connectors on this programme have already reached people experiencing domestic violence and worked with them, to enable them to achieve the outcomes that they want in a way that is acceptable and meaningful to them.

6.10 The above initiatives are commendable, and it is recommended that they continue to develop. However, when an informal/family carer is caring for a loved

one with challenging behaviours they need additional help and support to enable them to manage potentially dangerous situations, as this case has highlighted.

Information sharing and fora for discussion

6.11 The exchange of information between agencies was generally good, with one exception, that was the fax sent from the acute hospital to the mental health trust on 27th July which was not received until 17th September. This missing fax resulted in a delay of seven weeks. Prompt receipt of this referral is likely to have sped up the diagnostic process and led to more timely intervention. The diagnostic process in ruling out Parkinson's disease or another neurological condition before further testing for dementia involved referral and reporting systems across two different health Trusts.

6.12 Henry surrendered his guns, when his physical disability meant that he was no longer able to use them. Whilst some GPs raise the issue of holding a firearms licence with their patients when there is a risk that they maybe a danger to themselves or others, this is not done systematically by all GPs.

6.13 Henry and Mary had a good relationship with their trusted GP. Not all communities have access to a consistent GP, but primary and secondary care services are encouraged to refer on to appropriate services for information, support and advice soon after diagnosis, if this is acceptable to the person and their family.

Collaborative working, decision making and planning

6.14 There were many examples of good practice where organisations worked well together in supporting Mary and Henry within the parameters of what was acceptable to them and in the diagnosis and treatment of Henry's symptoms.

6.15 The social housing provider played an important role in supporting Mary and Henry and did so in a professional way reflecting the organisation's culture of safeguarding and domestic abuse awareness. However, the social housing provider recognised that further dementia care training was required for their staff and are addressing this.

6.16 The housing sector makes an important contribution to safeguarding adults, as highlighted in this DHR. The Norfolk Safeguarding Adults Board is reviewing how this sector can have the most impact on the Board and in safeguarding adult processes.

6.17 Mary and Henry had the continuity of a trusted professional in their GP, however other people living with dementia and their carers may not have this point of contact. Following the positive evaluation of the Admiral nursing service, the Norfolk and Waveney Sustainability Transformation Partnership should consider how this service or another model that provides trusted continuity of support to people living with dementia and their families can be rolled out across Norfolk and Waveney, in line with NICE guidance and the recommendations of the National Dementia strategy (2009).

7.0 Recommendations

7.1 Norfolk County Council and Norfolk and Suffolk Foundation Trust to work with carers and their families to empower them by: providing guidance on how to stay safe and keep patients safe, plan for emergency situations, de-escalation techniques and the provision of resources

7.2 Norwich and Norfolk University Hospitals Trust and Norfolk and Suffolk Foundation Trust to explore how to provide a smoother diagnostic pathway for people with dementia, considering the integration of physical and mental health clinics.

7.3 Norwich and Norfolk University Hospitals Trust and Norfolk and Suffolk Foundation Trust to explore how best to share information instantly in a reliable way, considering the use of electronic referrals and implement an effective system.

7.4 Norfolk and Waveney Clinical Commissioning Groups, alongside the police, to develop and implement a systematic process for GPs to flag patients who are at risk of misusing firearms in a way that presents a danger to themselves and/or others and to take appropriate action in advising that a firearms licence should be terminated, and social landlords informed.

7.5 All housing sector providers, including the couple's social housing provider, to provide dementia training for their frontline staff.

7.6 To ensure all Community Connectors across the Council are trained in dementia.

7.7 The Norfolk Safeguarding Adult Board to improve engagement with the housing sector, and develop an effective model of practice for domestic abuse safeguarding processes

7.8 The Norfolk and Waveney Clinical Commissioning Group to take a lead from the Norfolk and Waveney Sustainability Transformation Partnership in planning continuity of trusted support to people living with dementia and their carers, in line with NICE guidance, for example Admiral nurses.

Recommendations for the Home Office.

7.9 Section two, point 5 of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016) states: 'This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act). The Act states:

(1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself,
held with a view to identifying the lessons to be learnt from the death.

7.10 This statutory guidance does not take into consideration when the person who has committed the violence is not of sound mind and the victim has not been subjected to domestic abuse. In these circumstances, a domestic homicide review may not contribute to learning on the prevention of domestic abuse and is likely to cause additional distress to a family. Whilst there will always be some learning, these cases could benefit from a lighter touch approach.

7.11 Section eight of the Statutory Guidance (81) states: *All overview reports and executive summaries should be published unless there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review for this not to happen.* And *The content of the overview report and executive summary must be suitably anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others and to comply with the Data Protection Act 1998.* As explained in this report, it is challenging to anonymise a case in a small rural community, particularly when the story has been shared through the media. It would be impossible for a Domestic Homicide Report to remain anonymous as the story would be known to local people and would attract local interest.

Recommendation:

7.12 The Home Office to consider whether the methodology for a DHR could be modified for a more proportionate review, when the perpetrator is not of sound mind and there is no evidence to suggest any historic domestic abuse.

7.13 The Home Office considers how to protect the anonymity of the DHR report for small rural communities.