Ceredigion Community Safety Partnership

DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

'Betty'

Died: May 2019

Review & Investigation

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

Dissemination

This full and final report will be published by the Ceredigion Community Safety Partnership and will also be copied to those organisations mentioned below. The Individual Management Reviews, supporting agency chronologies and documentation will not be shared:

- *Police and Crime Commissioner for Dyfed Powys Police*
- *CSP Co-Ordinator*
- *Dyfed-Powys Police*
- *Betty's GP practice*
- *Hywel Dda University Health Board (primary Care Services)*
- *Ceredigion Community Safety Partnership*
- *Regional VAWDASV Board*
- *Regional Safeguarding Board*
- *Dyfed Drug and Alcohol Services*
- *Domestic Abuse Commissioner*

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Preface

The Ceredigion Community Safety Partnership would like to express its condolences and sympathy to Betty's family and friends.

Betty's death met the criteria for conducting a Domestic Homicide Review under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004[1], in that her homicide was committed by her husband. (He later pleaded guilty to her manslaughter).

At all times, the Domestic Homicide Review Panel has tried to view what happened through Betty's eyes. We would like to assure everyone that in undertaking this review, we have sought to learn lessons to improve the response of organisations in cases of domestic abuse.

The Independent Chair and Author of the review would like to express his appreciation for the time, commitment, and valuable contributions of the review panel members and contributing report authors.

[1] https://www.legislation.gov.uk/ukpga/2004/28/section/9

1. INTRODUCTION

1.1 This is the report of a Domestic Homicide Review (DHR) following the death of Betty in May 2019 at her home in Wales where she lived with her husband John. John later pleaded guilty to Betty's manslaughter. (Betty and John are not their real names).

1.2 The goal of a DHR is to play a part in bringing about meaningful change to reduce the likelihood of future homicides. During the review into Betty's death, the review panel were professionally curious and adopted an investigative approach to try to understand the dynamics of Betty and John's relationship as well as their individual perspectives and experiences. The panel examined whether professionals and agencies individually or collectively supported them and considered more generally what responses to domestic abuse were or could have been available to them both, including what might have helped or hindered their access to support. In doing this, as well as involving professionals, the panel sought to engage with those around Betty and John, including their family, friends, neighbours and the local community.

1.3 Betty and John were English and they had moved to Wales after their retirement. Betty was in her late 70s at the time of her death and John was over 80. They had known one another for 60 years and had been married for 57. They had no children.

1.4 Betty had worked in the education department of a local authority in the West Midlands before taking early retirement due to ill health; John had been a tool maker. They enjoyed reasonably good physical health and both had regular consultations and contact with their General Practitioner and were under the care of secondary care services during the period under review.

1.5 According to friends and neighbours, (and according to John – see later), Betty's behaviour had become increasingly argumentative and 'difficult' in recent years and there was real concern among them that Betty was mentally unwell. Although no formal diagnosis was ever made (or assessments undertaken under the Mental Health Act or the Mental Capacity Act – see later), a post-mortem examination of Betty found evidence of the onset of Alzheimer's disease.

Comment: *The Alzheimer's Society[2], say the disease is the most common cause of dementia. Estimates indicate there are about 44,000 people in Wales with diagnosed and undiagnosed dementia, with a significant proportion living in the community where care is provided, in the main, by family caregivers. They add that people with dementia may be unable to recognise their needs, to know how to achieve them, or to let other people know what it is that they need. This may cause them to act in ways that others might find challenging, including aggression. They say aggressive behaviour might be the person's*

[2] https://www.alzheimers.org.uk/about-dementia/types-dementia/alzheimers-disease

way of trying to achieve what they need, or it may be a sign of an attempt to communicate that a need isn't being met.

1.6 On the day before Betty died, she 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.

1.7 Early the following morning, when Betty and John were in the bedroom, an 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.

1.8 The police and paramedics arrived about 20 minutes later, but despite their best efforts, Betty could not be saved.

1.9 When John pleaded guilty to Betty's manslaughter, he was sentenced to three years and four months imprisonment. 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".*

1.10 Having considered all the evidence that is now available from Betty and John's friends and neighbours as well from professionals, it is the view of the DHR panel that a breakdown in Betty's mental wellbeing was the main cause of arguments and friction between the couple. There is no evidence to suggest that John was ever violent or otherwise abusive to Betty prior to the events that brought about her death.

Comment: *The review panel is keen to stress that they are not suggesting at all that Betty was to blame for what happened.*

1.11 John never considered himself to have been the victim of domestic abuse, but his presentations to the police, to his GP and to others were certainly in keeping with someone who was. As this report progresses, it will be seen that Betty was mostly unaware of how her behaviour was affecting John (and her friends), but that ultimately, she did realise she needed help. She telephoned a community health advocacy service who in turn notified her General Practitioner, but the opportunities that the calls presented to professionals to intervene were missed.

2. REVIEW TIMESCALES

2.1 In keeping with agreed protocol, in May 2019, the police notified the Ceredigion Community Safety Partnership of the circumstances of Betty's death, because her husband had unlawfully killed her.

2.2 In consultation with local partners, all of whom understand the dynamics of domestic abuse, the Chair of the Community Safety Partnership notified the Home Office of the decision to commission a Domestic Homicide Review in June 2019. The review commenced 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, meetings were held via a video conferencing platform, interspersed with numerous telephone and email conversations.

3. CONFIDENTIALITY

3.1 As mentioned above, Betty and John are pseudonyms. The names were chosen by the review Chair (and were agreed by John during an interview with him in prison). The Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016)[3] states that personal details and other identifying features, for example precise dates, must remain anonymous in DHR overview reports and associated executive summaries. This is to protect the identities of the victim, the perpetrator, their families, friends and neighbours and the agency staff who were involved with them.

3.2 This report is marked: '*Official Sensitive'* under Government Security Classifications 2018[4].

3.3 The review panel all signed-up to the following principles of confidentiality during the review process:

- *Information discussed by any agency representative within the ambit of a panel meeting would be strictly confidential and treated as such during the meeting and in the subsequent handling of any data considered at it*
- *The information was not to be disclosed to third parties without the prior agreement of the partners to the meeting*
- *Information shared should be relevant to the review*
- *Clear distinctions should be made between fact and opinion*
- *All agencies were to ensure that the minutes of meetings were retained in a confidential and appropriately restricted manner. The minutes would aim to*

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf
[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/715778/May-2018_Government-Security-Classifications-2.pdf

reflect that all individuals who are discussed during the meetings should be treated fairly, with respect and without improper discrimination. All work undertaken would be informed by a commitment to equal opportunities and effective practice issues in relation to age, disability, gender, gender identity, race, religion and sexuality.

4. SCOPE AND TERMS OF REFERENCE FOR THE REVIEW

4.1 After careful consideration, it was agreed to review each agency's involvement with Betty and with John between 1st November 2017 and the date of Betty's death in May 2019, subject to any information emerging that prompted a review of any earlier incidents or events that were relevant.

Comment: *November 2017 was when Betty and John first divulged to a professional (their solicitor) that they were having difficulties in their relationship. For context purposes though, commentary has also been made in this report about events (described by Betty and John's friends) that had occurred several years previously.*

4.2 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.*

5. METHODOLOGY

5.1 Upon notification of a potential domestic homicide, a multi-agency scoping exercise was undertaken to ascertain whether agencies had any record of involvement with Betty and/or with John in any context of relevance to the review. Only the following two agencies had been involved with them:

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

Agencies who provided negative responses were:

- *Adult Social Services*
- *Porth Ceredigion Targeted Intervention*
- *Mid and West Wales Fire and Rescue Service*
- *Wales Probation Service*
- *KSS Community Rehabilitation Company*
- *Alcohol Services – DDAS*
- *West Wales Domestic Abuse Service.*

5.2 The police and the University Health Board were asked to produce Individual Management Reviews (IMRs). They were also asked to include a comprehensive chronology of their involvement during the relevant period, details of any decisions that were made, what services were offered and provided to Betty and to John and any other action that may have been taken. Further, the IMRs were to be completed with the review 'Terms of Reference' in mind and were to consider not only whether procedures had been followed, but whether, on reflection, they had been adequate.

Comment: *The aim of an IMR is to look openly and critically at individual and organisation processes and practices and to provide an analysis of the service they provided. The IMR Authors were independent in that they had no previous involvement with Betty or with John or any line-management responsibility for staff who had been involved with them.*

5.3 The IMRs produced during this review were of a good standard. They were shared among the panel members having been quality assured by the respective agency and by the panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

5.4 This overview report has been compiled from analysis of a multi-agency combined chronology, information supplied in the IMRs, from open-source material and from discussions between the DHR Chair and John, two of John's (and Betty's) long-standing friends, a solicitor who had acted for them when they made their last Will and Testaments and with several of the couple's neighbours. Witness statements prepared by police officers who attended incidents have also been reviewed as have witness statements from other people who tendered evidence as part of the criminal investigation into Betty's death. The Chair's extensive knowledge of previous domestic homicide reviews and of aspects of domestic abuse have been

utilised, as have relevant publications about domestic abuse, specifically those affecting older people in Wales.

5.5 The review panel considered the coronial and criminal processes before contacting Betty's family, friends, neighbours and John to ensure that relevant information could be shared without risking compromise to either process.

6. REVIEW CHAIR AND AUTHOR OF THE OVERVIEW REPORT

6.1 The Ceredigion Community Safety Partnership 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.

6.2 ### THE REVIEW PANEL MEMBERS

6.3 During the course of the review, the following representatives have 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 Investigtion Ltd	
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

7. PARALLEL PROCESSES

7.1 There was a police investigation into the circumstances surrounding Betty's death which culminated in John being charged with Betty's murder. John later entered a plea of guilty to Betty's manslaughter, which was accepted by the court.

7.2 Betty's death was referred to the coroner who opened an inquest and then adjourned it because John had been charged with murder. The inquest has been 'adjourned indefinitely' based on John's conviction for Betty's manslaughter.

8. EQUALITY, DIVERSITY AND INCLUSIVITY

8.1 As mentioned previously, Betty was in her late 70's when she died; her ethnicity was white British. John was in his early 80's and he also is white British. English was their language of communication.

8.2 The Equality Act 2010[5] sets out nine protected characteristics. Discrimination which happens because of one or more of these characteristics is unlawful under the Act. The characteristics are:

- *Age*
- *Disability*
- *Gender reassignment*
- *Marriage and civil partnership*
- *Pregnancy and maternity*
- *Race*
- *Religion or belief*
- *Sex*

[5] https://www.legislation.gov.uk/ukpga/2010/15/section/4

- *Sexual orientation.*

8.3 The Act offers protection from discrimination for every individual. Importantly, the Act prohibits any protected status for domestic abuse and violence.

8.4 Domestic abuse can affect anyone, regardless of their sex, age or race, but women are more likely to experience repeat victimisation, be physically injured or killed as result of domestic abuse and experience non-physical abuse (including emotional and financial abuse), than men[6]. No evidence came to light during the review however, to suggest that Betty or John were knowingly discriminated against or were treated less favourably by any agency in respect of any protected characteristics as defined by the Act or that any protected characteristics had a detrimental impact on contact and response to any reported domestic abuse incidents.

Comment: *Research by the Dewis/Choice Project (see 12.16 later) asserts 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, but the GP Practice are sure their failure to identify potential domestic abuse between Betty and John was nothing to do with their respective ages.*

8.5 Although stereotyping older people is to be avoided, experience does show that some can be less likely to identify themselves as experiencing domestic abuse. They may feel less able to access services: they can be less aware than younger people of the services and options available to them: or they may believe that services are only for younger people, or people with young children[7]. As this report progresses, it will be seen that John did seek some support for Betty, but not in the context of domestic abuse.

Comment: *Paragraphs 11.3 to 11.22 of this report detail what John told the review Chair during an interview in prison and later over the telephone (he was released from prison in May 2021), about his knowledge of services and how to access them.*

8.6 As mentioned previously, no formal assessments of Betty were undertaken under the Mental Health Act or the Mental Capacity Act and the medical evidence is that there was never a clinical need to do so. The GP practice had no concerns about Betty's cognition or behaviour other than one incident which prompted the practice to write to her about her inappropriate behaviour towards a member of staff.

Comment: *The Mental Capacity Act 2005[8] describes someone who lacks capacity as a person who is unable to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken. There are principles under the Act that all adults have the capacity to make decisions on their own behalf, that someone who cannot make a complex decision may be able to make a simpler one and*

[6]https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforengland andwales/yearendingmarch2018
[7] Wydall, S., Zerk, R. Newman, J. 2015. Crimes against, and abuse of, older people in Wales: Access to support and justice working together. Report submitted to Older People's Commissioner for Wales. Available at: https://dewischoice.org.uk/
[8] https://www.legislation.gov.uk/ukpga/2005/9/contents

that a person cannot be deemed to lack capacity solely because they make an 'unwise' decision.

The main purpose of the Mental Health Act 2007[9] *is to ensure that people with serious mental disorders which threaten their health or safety, or the safety of the public can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others*.

8.7 No information came to light during the review to identify whether Betty or John followed any faith or religion and there was no indication that either of them had any sexual orientation other than heterosexual nor that either had a sex identity they had not been ascribed with at birth. No evidence was forthcoming to suggest that their sex precluded them from asking for or receiving services.

8.8 Although there are some references in this report to the use of alcohol by Betty, together with inferences that at times it may have impaired her judgement, alcohol use is statutorily excluded from the definition of disability under the Equality Act.

9. STRATEGIC GOVERNANCE

9.1 STRATEGIC GOVERNANCE OF VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE AND SEXUAL VIOLENCE IN WALES

9.2 In 2015, the Welsh Government passed the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (VAWDASV)[10]. The Act seeks an improved collective public sector response, stronger leadership and a more consistent focus on the way such issues are tackled in Wales and more importantly it seeks to stop abuse happening in the first place.

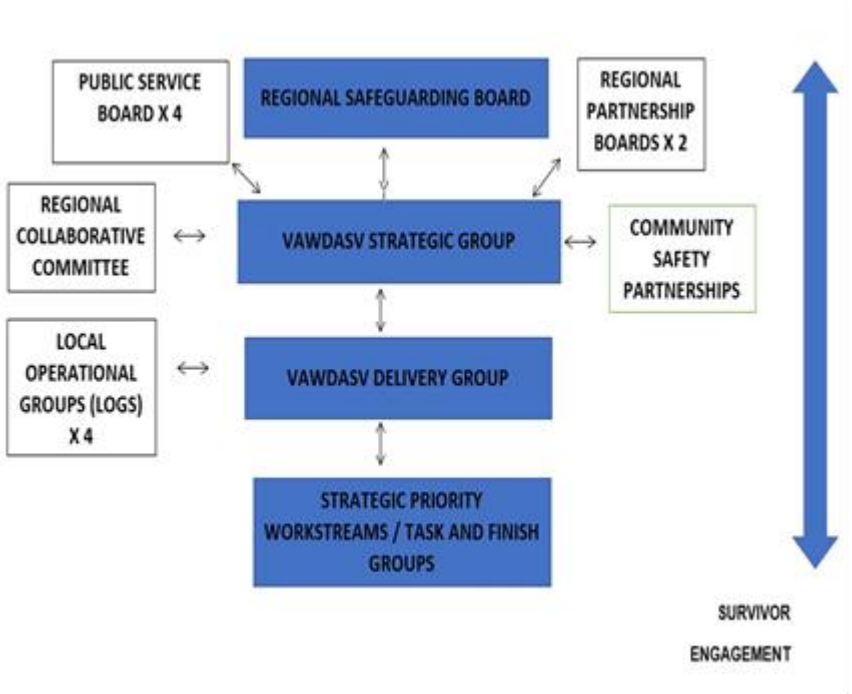
9.3 In line with the requirements of the Act, Mid and West Wales published its first regional VAWDASV strategy in November 2018. 'Safer Lives, Healthier Relationships'[11] outlines how the region will improve the response and support for anyone who is experiencing or has experienced domestic abuse, sexual violence or violence against women, hold perpetrators to account, ensure professionals have the tools and knowledge to act, increase awareness of the issues and how to access support and help children and young people to understand inequality in relationships and that abusive behaviour is always wrong.

9.4 The regional strategy contributes to the Welsh Government national strategy on violence against women, domestic abuse and sexual violence. The Mid and West Wales Safeguarding Executive has adopted the overarching objectives of the national strategy as drivers for the strategic priorities. The strategy sets out to provide the leadership and direction that will promote consistency and best practice for the way in which violence against women, domestic abuse and sexual violence is prioritised and tackled across the region. The collective vision within the

[9] https://www.legislation.gov.uk/ukpga/2007/12/contents
[10] https://www.legislation.gov.uk/anaw/2015/3/contents/enacted
[11] https://www.carmarthenshire.gov.wales/media/1213738/safer-lives-healthier-families-final-draft-mww-vawdasv-strategy-march-2018.pdf

strategy is for survivors, their children, wider family and communities to know how and where to get the help that they need, to provide that help in a consistent and co-ordinated manner, and to work towards a society in which no form of violence against women, domestic abuse and sexual violence is tolerated.

9.5 The governance structure around the Regional VAWDASV Strategy is set out as follows:



9.6 MALE VICTIMS OF DOMESTIC ABUSE

9.7 As this report progresses, comment will be made about factors that may affect older men around recognising domestic abuse and barriers they may face in disclosing it and there is little doubt that John was affected by them to some degree. Dozens of studies and surveys over the past several decades have shown that men of all ages and ethnicities are less likely than women to seek help for all sorts of problems, including physical health issues, depression, substance abuse and relationship issues, even though they encounter those problems at the same or greater rates than women. Determining the true extent to which men are victims of domestic abuse is difficult because they may be more reluctant to report it, but as mentioned previously, many more domestic violence incidents reported to the police are perpetrated by men as opposed to women.

9.8 It has been argued that men learn from childhood that they are not supposed to express vulnerability and that they should suppress emotional responses to the extent that by the time they are adults, they can genuinely be unaware of their emotions and how to articulate them[12]. Men with higher levels of traditional masculinity ideology have a negative opinion of seeking help because of their

[12] https://repository.canterbury.ac.uk/item/87122/masculinity-alexithymia-and-fear-of-intimacy-as-predictors-of-uk-men-s-attitudes-toward-seeking-professional-psychological-help

denial of vulnerability, a consequence of which can be an inability to have truly intimate relationship; men often conflate sex with intimacy[13].

9.9 The studies do indicate though a tendency for men to discuss issues around their physical or mental health with their intimate partner before finally taking steps to seek professional support, but when it comes to domestic abuse, for obvious reasons, a man is highly unlikely to ask the person who is abusing him if he/she thinks it a good idea that he seeks help to cope with the abuse.

9.10 Yet even when men do eventually seek help, there is evidence that less extreme forms of male distress may routinely go unrecognised[14] because men effectively abandon psychological reflection.

9.11 All victims of domestic abuse often face barriers to reporting what is happening to them. For men, there can be additional barriers such as:

- *They may be told that there must be something they did to provoke the perpetrator's abuse*
- *They can suffer shame, embarrassment and the social stigma of not being able to protect themselves 'Like a real man would'*
- *They can feel uncertain about where to seek help, or how to seek help*
- *Services are less likely to ask whether a man is a victim of family violence, and when they do ask, they are less likely to believe him*
- *Male victims can be arrested and removed from their homes because of the assumption that because they are male, they must be a perpetrator and not a victim. When this happens, children can be left unprotected from the perpetrator of the violence, leading many men to suffer the abuse in silence to protect their children.*

9.12 ## LEGAL DUTY

9.13 The Social Services and Well-being (Wales) Act 2014[15] places a legal duty on a local authority to make or cause enquiries to be made if it is believed an 'adult' (including an older person) is experiencing, or is at risk of, abuse or neglect. The local authority will determine what action should be taken by the authority or others.

9.14 The Welsh Government funds a national, seven days a week, confidential 24-hour helpline for those experiencing domestic abuse, sexual violence and other forms of violence against women and gender-based violence. It is known as 'The Live Fear

[13] Psychology of Men and Masculinity (Vol. 6, No. 1, pages 73-78)
[14] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0049779
[15] www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf

Free helpline'[16] and it is a gender-responsive information and support service for women, men, children and professionals who want to know more about the support services available to victims in Wales.

Comment: *The Live Fear Free helpline is available to both the public and to professionals who suspect abuse is taking place even when the victim has not disclosed it. The helpline is designed to provide a professional with the most appropriate information to help support the person who is affected by the abuse, including contact details of the relevant specialist domestic abuse support services in the area.*

9.15 The Welsh Government leaflet 'Information and Guidance on Domestic Abuse; Safeguarding Older People in Wales[17] describes how a pathway to support older people affected by domestic abuse seeks to align existing or forthcoming statutory duties which may relate to older people, with good practice in relation to domestic abuse. The document includes a flowchart which refers to the 'Duty to report' and the 'Duty to enquire' under the 2014 Act, known collectively as 'Ask and Act'.

Comment: *This document can be found on the internet and within the Hywel Dda University Health Board and it is available on their Safeguarding intranet page and to all professional groups within acute, community, primary care and mental health services and is referred to in adult safeguarding training. In May 2019 and again in August 2020, it was re-issued to raise awareness of domestic abuse involving older people.*

9.16 ## 'ASK AND ACT'

9.17 The document describes 'Ask and Act' as a process of targeted enquiry to be practiced across the public service to identify violence against women, domestic abuse and sexual violence. The term 'targeted enquiry' describes the recognition of indicators of violence against women, domestic abuse and sexual violence as a prompt for a professional to apply a 'low threshold' and ask their client whether they have been affected by any of these issues. The stated aims are to increase identification of those experiencing violence against women, domestic abuse and sexual violence; to offer referrals and interventions for those identified which provide specialist support based on the risk and need of the client; to begin to create a culture across the public service where addressing violence against women, domestic abuse and sexual violence is an accepted area of business and where disclosure is expected, supported, accepted and facilitated; to improve the response to those who experience violence against women, domestic abuse and sexual violence with other complex needs such as substance misuse and mental health issues; and pro-actively engage with those who are vulnerable and hidden, at the earliest opportunity, rather than only reactively engaging with those who are in crisis or at imminent risk of serious harm.

[16] https://gov.wales/live-fear-free
[17] https://gov.wales/domestic-abuse-safeguarding-older-people

9.18 APPLYING 'ASK AND ACT' WITH OLDER PEOPLE

9.19 The document adds that once rolled out nationally, 'Ask and Act' should be applied with older people who display potential indicators of violence against women, domestic abuse and sexual violence. The indicators include medical symptoms (such as depression, anxiety or medically unexplained pain), signs linked to the demeanour and behaviour of the client, including attitudinal change or a piece of information or pattern of behaviour which merits enquiry (known as 'cues').

9.20 DOMESTIC ABUSE

9.21 Domestic abuse[18] is defined as:

'Any incident of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- *Psychological*
- *Physical*
- *Sexual*
- *Financial*
- *Emotional'*

9.22 Domestic abuse can happen to anyone, regardless of age, gender, race, sexuality, economic position, and geography. However some key risk factors are associated with greater risk, for example, women are more likely to be victims of domestic abuse, sexual orientation can be a disincentive to reporting for fear of being 'outed', individuals with disabilities may not feel able to report concerns due to possible reliance on the perpetrator to meet day to day needs and those with children under five show a greater reluctance to report concerns for fear of breaking up the family unit, losing the family home or impacting upon employment opportunities or prospects. Although it is well acknowledged that domestic abuse can affect anyone in society, the experience of some groups may not always be visible, so there is always a need to raise awareness and to understand the experience of those groups. The abuse experienced by older people, as with others, can vary from emotional abuse to physical, sexual, financial, psychological abuse and neglect, with many victims experiencing a combination of abusive behaviours.

Comment: *According to Safelives[19], on average, older victims experience domestic abuse for twice as long before seeking help as those aged under 61, yet they are hugely underrepresented among domestic abuse services and 80% of older adults are not visible to*

[18] Home Office Circular 003/2013: new government domestic violence and abuse definition
[19] Safelives (2016) Safe Later Lives: Older people and domestic abuse.

services at all. Previous studies focussing on domestic abuse, have often neglected to include the experiences of older people[20].

9.23 There is also evidence from criminal cases, domestic homicide and historic serious case reviews that domestic abuse issues for older people often go unrecognised, which means that protective or supportive measures that may have reduced the risks of harm are not put in place. Safelives[21] point out that older people may also be particularly affected by what may be perceived as 'low level' individual incidents which can, as part of a longstanding pattern of cumulative abusive behaviour, have consequences that can equal or surpass any individual incident.

Comment: *Various research[22] shows that few domestic homicide reviews of older people identified a history of domestic abuse. This may be because older people do not recognise the phenomenon of domestic abuse or an older generation tolerate what now might be considered as coercion and control or violence within a marriage, as historically society has considered these to be private matters.*

Other analysis[23] has shown that older people are unlikely to raise concerns about domestic abuse or ageist stereotypes and narrow understandings of domestic abuse mean older people are often over-looked.

9.24 ## COERCIVE AND CONTROLLING BEHAVIOUR

9.25 Where there is a personal connection between two parties, controlling or coercive behaviour is a criminal offence[24]. It can take a range of forms but often involves a pattern of continued and repeated abuse. This abuse may appear routine or 'low-level' to the outside observer, but its hidden significance to the victim will often cause anxiety and fear. It can also create an environment in which increasingly harmful conduct is accepted as normal by the victim. Abusers can be imaginative in the ways in which they control, abuse or humiliate their partners and also in the consequences that result from disobeying. Practitioners dealing with domestic abuse incidents should be alert to patterns of behaviour that could be controlling or coercive. Coercive control is usually personalised, in that it means something to the victim even when the meaning is not apparent to anyone else. Individual characteristics such as a disability, membership of a closed or marginalised community, or being a non-English speaker can increase the risk of isolation for a victim and make it easier for a perpetrator to establish controlling or coercive behaviour.

9.26 Examples of controlling or coercive behaviour include, but are not limited to:

- *Constant criticism*

[20] Zerk, R. (2015) 'Barriers to disclosure in later life', paper presented at the XXXIIII International Congress on Law and Mental Health, Vienna, 15th July 2015.
[21] https://safelives.org.uk/policy-evidence
[22] Benbow, S. M., Bhattacharyya, S., & Kingston, P. (2018). *Older adults and violence: An analysis of domestic homicide reviews in England involving adults over 60 years of age.* Ageing & Society. doi:10.1017/S0144686X17001386
[23] Bows H. (2018) *Domestic Homicide of Older People (2010-15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK,* British Journal of Social Work (2018) 0, 1-20, Oxford Press
[24] Section 76 of the Serious Crime Act 2015.

- *Humiliation*
- *Jealous or possessive behaviour, for example, frequent phone calls to check where the victim is and what they are doing or checking activity on the victim's phone or e-mail*
- *Threats of suicide/homicide/familicide*
- *Threats or actual self-harm*
- *Threats of harm to pets*
- *Controlling family finances, withholding or restricting the victim's access to money*
- *Isolating the victim by not allowing them to visit friends and family or for family and friends to visit them*
- *Restricting a victim's movements, for example, confining them to a room, being made to account for their time*
- *Dictating what a victim wears or how they do their hair*
- *Dictating a victim's routine or schedule, for example timing of shopping trips*
- *Intercepting communications, for example, letters, messages or phone calls.*

9.27 The Welsh Government 'Safeguarding older people in Wales' document mentioned in paragraph 9.15 states that, *'The acknowledgement of coercive and controlling behaviour as part of domestic abuse of older people is very important. If consideration of coercion is not made it could lead to a missed opportunity to identify abuse. However, whilst some perpetrators may be coercive and deliberately premeditated in their actions, others may be reacting to circumstances where they are unable to cope with the level of care required by the victim. In addition, there may be a clinical causality to the abuse: for example, as a result of dementia. The use of coercive control techniques may feature less prominently where abusive behaviour is a consequence of unintentional neglect or the emotional situational stress experienced by the carer'.*

9.28 The same document points out that where an older person is the carer of an abuser, they may feel a sense of obligation to continue the care, despite the abuse. It adds that whilst the situation may occur due to the commonly understood dynamics of domestic abuse and may be pre-existing to the caring role, its likelihood increases where the person who is being cared for:

- *Has health and care needs that are too complex for the carer and require long term support*
- *Does not consider the needs of the carer or family members*
- *Treats the carer with a lack of respect or courtesy*
- *Rejects help and support from outside, including breaks*
- *Refuses to be left alone by day or by night*
- *Has control over financial resources, property and living arrangements*
- *Engages in abusive, aggressive or frightening behaviours*
- *Has a history of substance misuse*
- *Has or is perceived to have unusual or offensive behaviours*
- *Does not understand their actions and their impact on the carer*
- *Is angry about their situation and seeks to punish others for it*

- *Has sought help or support but did not meet thresholds*
- *The caring situation is compounded by the impact of the nature and extent of emotional and/or social isolation of the carer or supported person.*

9.29 As mentioned earlier, it is the view of the review panel that a deterioration in Betty's mental wellbeing was the cause of arguments and friction between her and John and there is absolutely no known history (or even any suggestion by those who knew them well), that John was ever violent or otherwise abusive towards Betty prior to the events that brought about Betty's death.

9.30 Of course, the review panel has had the benefit of hindsight in reaching these conclusions as well as the opportunity to consider evidence and information from Betty and John's friends and neighbours that had not been known to professionals prior to Betty's death. Even though John did not consider himself to have been the victim of domestic abuse (see below), his presentations to the police, to his GP and to others were in keeping with someone who was. It follows therefore that those presentations (and what Betty told her GP (and the Community Health Council[25] (CHC) advocacy service) should also have indicated that Betty was abusing John.

10. PARTICIPATION IN THE REVIEW

10.1 The following paragraphs summarise what John told the review Chair and what some of Betty and John's friends and neighbours have said. It will be seen that the friends and neighbours say that John was bullied by Betty, but John is adamant he was neither bullied nor was he ever a victim of domestic abuse. There is however an overwhelming feeling among the friends and neighbours that John found himself in an impossible situation and that he was in effect 'let down by the system' because he had tried hard to find help for Betty with her mental health issues, but that no one could intervene because she did not acknowledge she required support.

10.2 The information has been included solely to bring context to what was happening in Betty and John's relationship. As mentioned previously, the review panel is keen to stress that it does not consider Betty was to blame for what happened, nor does it seek to minimise nor condone what John did.

10.3 ### JOHN

10.4 The review Chair wrote to John to explain that a domestic homicide review was taking place and to ask whether he would be prepared to participate in it. He agreed and arrangements were made to visit him in prison in March 2020, but due to Covid-19, the one-to-one visit had to be cancelled. Eventually, a video conferencing meeting was arranged instead.

10.5 John said there isn't an hour goes by when he doesn't think of Betty, who was the love of his life. He added that he deeply regrets what happened and to this day he

[25] http://www.wales.nhs.uk/sitesplus/899/page/99722

still doesn't really know why he did what he did or even exactly what did happen. He said that in all the 60 years he had known Betty, he had never *"So much as laid a hand on her"*.

10.6 John said that Betty was very much misunderstood by those who didn't know her as well as he did. He said she was a highly intelligent woman who was very organised and focussed, but she could appear forceful and opinionated at times, but the reality was completely different. He added that Betty was one of the kindest and most considerate people he had ever known and that they had had a wonderful marriage.

10.7 John also said that he and Betty had a very pleasant life. They had a lovely home which they owned outright, they lived in a nice village and had kind and considerate neighbours. He added that they had no financial worries whatsoever. John said he spent a lot of his time 'doing up the house', working in the garden and 'fiddling around with mechanical things', whilst Betty was the organiser and the planner.

10.8 John said that since Betty's death, several of their friends and neighbours had supported him, including making attempts to persuade the authorities to release him from prison early and even by helping him financially to ensure he was able to return to his own home when released from prison. When they were able (before Covid-19), they visited him in prison and during the pandemic they were in regular contact by telephone.

10.9 He said Betty had not been a very sociable person and that if given the choice, she would always prefer to 'Keep herself to herself'. Consequently, when friends and neighbours did see or hear Betty it was usually when she was really struggling with her mental health issues and that during those periods, which sometimes were very short-lived, she could come across as being not a very nice person. John added that during the last three years of her life, Betty's behaviour had become increasingly erratic and difficult and that he had 'opened-up' to his neighbours about it out of desperation, which may have made them think he was being controlled or bullied by Betty, but the reality was completely different.

10.10 John said that Betty could be perfectly okay for weeks on end, and then suddenly and for no apparent reason, she would 'Fly off the handle' and become verbally abusive. Sometimes Betty would start screaming at someone on television over a political issue that he knew she didn't even have any interest in and then suddenly, she would become 'The real Betty' again; it was as if someone had flicked a switch. He said that sometimes after she had calmed down, she would say things like *"Please don't ever leave me, you're my rock and I'd be lost without you"*. He added that occasionally Betty would also smash crockery and ornaments in the house, some of which had great sentimental value to her. He said that no matter how hard he tried, he was unable to reason with her and that the more he tried to calm her down, the worse it appeared to make her.

10.11 John said that Betty would tell him that he either no longer loved her or that he was more interested in watching television or working in his shed than he was in her. He said he realised after a while that the best way to diffuse the situation was to leave the house temporarily. He said he either slept in his Land Rover, in local bed and breakfast accommodation or he would drive to the Midlands to see his friends. He added that he could never stay away for long though, because he was so worried about Betty.

10.12 John added that many years previously Betty would sometimes consume too much alcohol, but that she had then stopped altogether. Recently however, Betty had started drinking again. He said Betty had never threatened him physically, but he was worried that when she was in a 'rage', especially if she had been drinking and was throwing objects around the house, she might accidentally injure herself.

10.13 John said that during the two years leading up to Betty's death, he was at his 'Wit's end' and he didn't know what to do. He said he and Betty even discussed getting a divorce even though neither really wanted one and that the only reason he approached their solicitor about it was because he didn't know where else to go for help.

10.14 John said it was obvious that Betty had a problem with her mental health and that out of desperation, he began trying to find support for her, but he always knew that Betty would not willingly accept help even if it was offered, because she never really accepted she had a problem. He said he scoured the telephone directory and the internet looking for help and on one occasion, he telephoned what he thought was a mental health support line, but in fact it was the police. He added that the police came to the house and did their best to persuade Betty to let them take her to hospital, but she would not go. The police also arranged for a mental health nurse to go to the house, but her efforts to persuade Betty to accept help came to nothing. John said that the police visit to their house later became a focus of Betty's 'rages' with her accusing him of embarrassing her in front of the neighbours.

Comment: *It is now known that two days later Betty tried to find the mental health nurse and that she telephoned a Community Health Council advocacy service asking for help (see paragraph 11.11 onwards).*

10.15 John said he spoke to his GP about Betty, hoping to get some mental health support for her, but he was told that unless Betty herself accepted help, there was nothing that could be done. The GP offered to visit Betty at home, but John said he thought that was probably pointless because Betty was adamant there was nothing wrong with her.

10.16 John said he never thought about the term 'domestic abuse', because he was not the victim of it and Betty was certainly not a perpetrator of it; she was simply a woman who through no fault of her own sometimes acted out of character, and that because he was 'In the firing line' he bore the brunt of it.

10.17 The review Chair and John then had a conversation about their neighbour's impressions of what had been happening between him and Betty. He understood why they might think he had been abused by Betty, but insisted they were wrong and that he and Betty had just been a normal couple and that any difficulties they had experienced were temporary and were wholly caused by her mental ill-health.

10.18 John said he was aware that some might think he was 'Looking through rose-tinted spectacles', but that he genuinely was never coerced or controlled by Betty in any way. He added that at no time during their life together did Betty seek to force her will upon him, but that they were very different people. He, for example, was never interested in financial matters, but Betty was, so she just took on the role of managing their finances. He said they were not short of money and that he was always able to buy what he wanted. John also said that Betty encouraged him to have friends and to 'Go for a pint' with them whenever he wanted, and that he did so every Friday. He said that had he wanted to, he could have gone out every day, but that he was more than content with his life until Betty became ill.

10.19 John said that before Betty died, neither the police, the GP nor his friends or neighbours ever mentioned the term 'domestic abuse' to him. The review Chair asked him, hypothetically, what might have happened had it been mentioned. John said he would probably have been dismissive of it because his perception of domestic abuse was one of physical assault by a husband upon his wife. He added that he would only have engaged with a domestic abuse service had someone been able to convince him it would have helped him secure support for Betty's mental ill-health. John said he had never heard of domestic abuse perpetrator programmes, but that Betty would never have attended one anyway, firstly because she wasn't a perpetrator and secondly because she would never have wanted anything to do with what she would have described as 'The do-gooder brigade'. He said that being from an older generation, he (and Betty) may have had a bias against services of that nature because of their old-fashioned outlook of 'Just getting on with life'. He also said that he found it difficult to discuss his private life with anyone, probably because of his gender and his age, but that he had been forced into doing it because he had been so concerned about Betty.

10.20 Finally, John said that he was the only person to blame for what happened to Betty but nevertheless he strongly feels that 'The system' had let Betty down because she was clearly not well, and no-one was able to do anything to help her.

10.21 ## BETTY'S FAMILY

10.22 The review Chair wrote to Betty's two sisters and her brother asking if they would be willing to participate in the review. They were also sent the Home Office information leaflets for family members about domestic homicide reviews. 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.

10.23 **BETTY AND JOHN'S SOLICITOR**

10.24 The Chair of the review interviewed the solicitor at his office. He had first been contacted by Betty in November 2017 about a dispute with some neighbours in relation to a tree in their garden. Following a review of the situation, the solicitor had told Betty that nothing could be done about it.

10.25 In September 2018, Betty told the same solicitor that she and John wanted to make Wills.

Comment: *The Wills contained nothing of significance to this review.*

10.26 The next time the solicitor had any involvement with either Betty or John was at the beginning of May 2019, when John visited his office to discuss divorce proceedings. John said it was Betty who wanted a divorce and not him, adding that he thought Betty was ill, because over recent years, she had become increasingly argumentative towards him and to everyone else. The solicitor told John that because he had acted for both he and Betty in respect of their Wills, he could not act for him in divorce proceedings.

10.27 John indicated to the solicitor that he had spoken to Betty's GP about his concerns for her and that he had attempted to source some counselling for Betty, but that everyone had made it clear to him that unless Betty wanted to engage with services, they could not intervene.

10.28 The solicitor said that at no time did John talk unkindly of Betty and that it was clear he loved her and wanted to help her. The solicitor told John that Betty's GP and the counsellors had been correct and that there was nothing anyone could do to help Betty if she did not want it.

10.29 John told the solicitor that he did not want a divorce and that he was really worried about Betty. He added that by mistake he had called the police to his house (when he had meant to telephone mental health services) and that since then, Betty had continually berated him and it had left him in an unhappy situation at home. The solicitor advised John to leave Betty and he offered to give John the details of other solicitors who might be able to act for him, but John declined the offer.

10.30 A few days later, Betty telephoned the same solicitor to ask how much a divorce would cost and the solicitor told her that he was unable to act on her behalf. During the call, Betty was also shouting to John about him never preparing her a meal and about him buying her an identical ring on consecutive birthdays. John then came on the line to tell the solicitor that Betty was continually berating him and that he had been keeping out of her way. The solicitor said he felt he had no alternative but to terminate the call.

10.31 **BETTY AND JOHN'S FRIENDS**

10.32 **FRIEND ONE**

Comment: *The interview with Friend One was conducted over the telephone because of issues around Covid-19.*

10.33 Friend One had known Betty and John for over 23 years. As mentioned at paragraph 1.6 of this report, on the day before she died, Betty and John had an argument. John had then driven to Friend One's home in England. The friend told the review Chair that John was clearly very upset, so he made him a meal and offered him a bed for the night, but John declined, saying he needed to get back home to look after Betty because he was so worried about her.

10.34 John told Friend One that he didn't know what to do and that he had sought advice from his GP and the police, but they had been unable to do anything to help.

10.35 The friend said that up until a few years before Betty's death, he had thought the relationship between Betty and John had been good and that they got on well together; he described them as being 'just a normal couple'.

10.36 Friend One added that he was aware that during the three years before her death, Betty had fallen out with lots of people, including her best friend (Friend Two). In Friend One's own words, *"She would just turn nasty and jump down your throat".* The last occasion Friend One spoke to Betty was at his house maybe one or two years before her death. Betty and John had said they were going to get a puppy dog and Friend One had asked Betty why they would do such a thing when John was already over 80. According to Friend One, Betty *"Flew off the handle"* with him. He said he had to tell her that it was not okay for her to talk to him like that.

10.37 **FRIEND TWO**

Comment: *The interview with Friend Two was also conducted over the telephone because of Covid-19.*

10.38 Friend Two had known Betty and John for nearly 30 years. She described her relationship with them both to have been close other than during the three years prior to Betty's death after Betty had decided that she did not want their friendship to continue.

10.39 Friend Two said that when she first met Betty, it was in a professional capacity. Friend Two had represented Betty at an industrial tribunal. She said helping Betty had been very time consuming and consequently they had spent a lot of time together. Friend Two said that Betty and John became her best friends and that she thought of them as an older brother and sister. Their relationship was such that they stayed at each other's homes for weekends and went on holidays together.

10.40 Friend Two said Betty was a complex character. She was articulate and very vocal, especially when it came to politics. She described John as being a man of simple tastes, who had a 'Laid-back' temperament. All he wanted was a quiet life. He enjoyed the occasional drink in his local pub with friends, working on his car and generally just helping people out.

10.41 Friend Two explained that Betty would be laughing hysterically one minute and then suddenly she would be in a raging temper. When that happened she became abusive, rude and vitriolic and would hurl awful abuse towards anyone who sprang to mind. Friend Two added that initially Betty would have an outburst like that about once every six weeks, but in the last few years of their friendship it became almost a daily event. Friend Two said there was no apparent trigger for the outbursts and that they would often begin with her seeing something or someone on the television with whom she disagreed.

10.42 Friend Two said that Betty knew her behaviour was at times irrational and destructive, but that she was just unable control it. When Betty had calmed down, Friend Two said to her on several occasions, words to the effect, *"It only takes two doctors you know"*, (referring to mental health assessments) and Betty would laugh and say, *"Yes I'd be sectioned wouldn't I?".*

10.43 **BETTY AND JOHN'S NEIGHBOURS**

Comment: *The interviews with the neighbours were all conducted on video conferencing platforms.*

10.44 A couple who lived quite close to Betty and John said that John was a very placid, mild-mannered person who was very easy to get along with. (They were in regular telephone contact with him in prison and pre-Covid-19, had visited him there). They said he was a 'hands-on', practical person who appeared to be enjoying his retirement and that he liked spending his time in the garden and working on various projects around the home. Socially, he went into the town by taxi most Friday tea-times for a drink with friends and would return a few hours later.

10.45 They said that Betty was completely different to John and they had little direct contact with her. The neighbours said they often heard Betty shouting and using bad language at John, which was often followed by the sound of doors slamming. They never heard John raise his voice in response and they gained the impression that his way of dealing with it was simply to walk away. John was clearly embarrassed about it and on the few occasions it came up in conversation, he said that he had tried to get Betty some help with her mental health, but that when it had been offered, she had insisted she did not need it.

10.46 The neighbours said they had never considered John's situation in terms of domestic abuse and that John had certainly never suggested he felt he was a victim of it. They say that even now, John still talks of Betty in the fondest of terms and that they know he is full of remorse for what happened.

10.47 Another neighbour, a professional social care practitioner, also participated in the review. She said her husband had become close friends with John. She also got to know John quite well. Although John was a quiet and private man, he would occasionally tell them how worried he was about Betty's mental health. He asked them for advice and they told him to contact the police if the situation began to get out of control, because they (the police) would then involve mental health services if the situation merited it. They also suggested he should speak to Betty's GP in the hope that it might be possible to initiate a mental health assessment for Betty.

10.48 The neighbour also knew Betty, but not very well because she tended to keep herself to herself. She said 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. The neighbour said that in hindsight, she thinks John was controlled and coerced by Betty and that it had become more severe in recent years. She added that she never thought of John as a victim of domestic abuse and that her focus had always been around Betty's mental health and how best to get her the support she so clearly required.

10.49 Finally, the neighbour 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. For several weeks John had been sleeping in his old Land Rover or in bed and breakfast accommodation because Betty (in his words) *"Had just lost it",* and he wanted to diffuse the situation. The neighbour 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.

11. AGENCY CONTACT WITH BETTY AND JOHN

11.1 There was very little agency contact with either Betty or John. The following is a summary of what contact there was, together with some review panel observations about it.

11.2 ### FEBRUARY 2018

In February 2018, Betty told her GP that she was in low mood and that she had been drinking recently due to illnesses and bereavements in England. The records indicate that she said she had now stopped drinking, but that she was concerned that internal damage might have been caused by it. Arrangements were made for Betty to undertake a liver function blood test.

Comment: *Many years previously, Betty had been recorded as being a heavy drinker. In 2016 the records indicated she was teetotal and in 2017 they indicated she was an occasional drinker. During this review, the GP has been asked whether consideration was given to referring Betty for support in respect of her low mood and her use of alcohol. The response was that because Betty's alcohol intake had stopped, the consultation was focused on possible damage that may have been caused through her recent alcohol intake rather than concerns about her low mood.*

An expectation of the Dyfed Drug and Alcohol Service would have been for at least a brief intervention conversation to have taken place with Betty about whether she would have liked support from substance misuse services. The same expectation related to John who could have been offered 'Concerned Other' support. The service routinely screens for domestic abuse in all their assessments of 'Concerned Others' and 'Substance Users' regardless of gender or age.

11.3 JUNE 2018

In early June 2018, John telephoned the police saying he and Betty had been having relationship difficulties for two years, but matters had escalated over the past few months. He said Betty had been smashing things, going into fits of rage, that she was uncontrollable and that when he had arrived home earlier that evening, she had been intoxicated and had wanted to drive to get some more alcohol, so he had taken her car keys from her. 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. He said he did not know whether Betty had a mental illness, but that such incidents were becoming more frequent. He said he wanted advice and that he had been sleeping in his car and in bed and breakfast establishments to avoid Betty.

Comment: *John told the review Chair that he had not known at the time that he was speaking to the police; he thought he had telephoned a mental health helpline.*

11.4 When the police arrived, John apologised for having called and said he hadn't known what else to do. He added that he was concerned about Betty's mental health and that he had wanted medical advice rather than the police. He said he and Betty had been enjoying the day because the weather had been nice, but Betty had become emotional after he had declined to sit down and listen to classical music with her. She had reacted by saying that he no longer showed her any affection and that she thought he no longer loved her. John said that Betty had been drinking wine throughout the day, adding that he wasn't sure whether she was just unhappy or whether she had some underlying mental health issues.

11.5 The other officer noticed some broken crockery on the kitchen floor. Betty said she was fine and that there was no need for the police to be there. She admitted she had broken the crockery and she demanded to know what John had been saying about her. The officer told her that John had not said anything unkind about her and that he was only concerned for her wellbeing. Betty said that if John really was that concerned, then he would at least sit and listen to music with her.

11.6 Betty giggled on occasions and suggested to the officer that she (the officer) was accusing her of being 'Mad'. The officer asked Betty if she would allow them to take her to hospital because they were concerned for her well-being, but in a very insistent tone, Betty said *"I'm sorry dear, I know you're only trying to do your job, but I will not be attending the hospital with you".*

11.7 The officers asked Betty if she would be prepared to be visited by a Triage Team, which consisted of a mental health worker and a police officer. Betty said that would be okay, but she insisted that she had no issues with her mental health and that she would not visit a doctor's surgery or a hospital. She explained that she and John had spent many years in Mid Wales, but that she did not have many friends locally although she did have friends who 'Lived away' with whom she would visit for a couple of nights every now and then. She said John enjoyed going to the pub on occasions and that he had a few friends locally, but mostly he enjoyed working in the garden and on a car in the shed. Betty said she and John were not getting any younger and all she wanted was to enjoy the time they had left, but that John was only interested in his garden and cars and watching war films on television. She then wrapped her arms around herself and said that all she wanted was to be held by John.

11.8 In the presence of the officers, Betty then asked John why he no longer showed her any affection and John referred to some Jewellery he had recently bought for her. Betty said she was not materialistic, and she then attempted to give the piece of Jewellery to one of the police officers, before saying that she was unhappy in her relationship and that she and John should go their separate ways.

11.9 The officers explained that even though no criminal offences had been alleged, they had to follow their force policy by taking positive action and insist that John and Betty separate for the evening. John said he was prepared to spend the night either with a friend or he would stay in local bed and breakfast accommodation.

11.10 The Community Psychiatric Nurse (CPN) member of the Triage Team who attended has told this review that Betty was in the lounge when she got there. She spoke to her alone and recalls Betty saying she had had a *"Couple of Whiskeys".* Betty told her 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. Betty added that when they had been younger, it had not been a problem because they had a social circle, but now they were older, it was more of an issue. The CPN recalled that Betty and John had a lovely home and that Betty said they had lots of money and could pay for someone to work on the house, but that John was still *"Climbing ladders"*, and that he would spend *"All day out there".* The CPN added that there was no sign of Betty having a severe or enduring mental illness, which would have required her (the CPN) to have acted immediately.

Comment: *The CPN has been asked whether she considered offering to refer Betty into substance misuse services after she had said she had consumed the whiskey. The CPN said that Betty had told her that she had only opened the whiskey bottle to annoy John (because it was his whiskey) and that she hadn't drunk any, so a referral was not a consideration.*

11.11 Two days later, Betty telephoned the Community Health Council (CHC) advocacy service and left two voicemail messages for them. In the messages, Betty said she had been visited by a mental health nurse and a police officer and that they had

asked her if she needed help and she had told them she did not. She said she had changed her mind and that she was trying to track-down the mental health nurse. Betty said she needed immediate help because she was being aggressive with her husband and was smashing up the house and was drinking all day.

Comment: *Community Health Councils are the independent voice of people in Wales who use NHS services. They encourage and support people to have a voice in the design and delivery of NHS services and provide a link between those who plan and deliver NHS services, those who inspect and regulate it and those who use it.*

11.12 A CHC Advocacy Support Officer (ASO) telephoned Betty the same day to ask for her consent to notify her GP surgery about her calls, and Betty agreed. The ASO then telephoned the GP Practice Manager who initially said they would send a letter to Betty, but the ASO said that because Betty had said she was being aggressive towards her husband, it required immediate action. The ASO also sent an email to the practice manager stating the following: *'Further to my telephone call to you this morning, we spoke about one of your patients under the care of* [Doctor]. *She has contacted us today raising concerns regarding her wellbeing. She told me she was visited by a mental health nurse from* [Town] *on Wednesday evening along with a police officer from* [Town]. *They asked if she needed any further help and the patient said no. She has now however decided that she does need further help and is trying to track this mental health nurse down. As we are not medically trained and only deal with complaints I am referring this patient over to you. As discussed on the phone this morning, she requires immediate help as she said she is being aggressive with her husband and is smashing up the house and drinking all day but she does not know why.'*

11.13 The CHC telephoned the practice manager three days later (after the weekend) to ask what had happened. The practice manager said he had telephoned the crisis team, but they had said they had not been involved with Betty. The crisis team said they would contact the CPN. The Practice Manager said he would chase it up after a few weeks. He said that should Betty contact the CHC again they should contact the GP surgery or better still, Betty should make an appointment to see the GP. The ASO then telephoned Betty to suggest she make an appointment with the GP; Betty said she would, although it appeared to the ASO that Betty was keen to end the conversation.

Comment: *The practice manager made an entry in the patient record stating the CHC advocacy service had been in touch and that Betty had been seen by the Crisis Team and had declined intervention.*

John had not been aware of Betty's conversations with the CHC until he was told about them by the review Chair.

11.14 The day after Betty had called the CHC, John went to his local police station and said he believed Betty might be suffering from mental ill health. John was advised to encourage Betty to book an appointment with her GP.

11.15 Betty did make an appointment and she told her GP that she wanted her husband to cuddle her and that he never discussed anything in life and avoided arguments. The medical notes indicate that Betty said she had been drinking more and that she blamed it on her husband.

Comment: *This consultation was only four days after Betty had made the telephone calls to the CHC and the ASO had notified the Practice Manager about it. It has been confirmed that the practice manager made an entry in Betty's patient record about her interaction with the CHC, so there was a clear missed opportunity by the GP to have referred Betty into substance misuse services and to have asked her about her aggression towards John and to have considered sourcing her (and John) appropriate support.*

11.16 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 complaining that he did not cuddle her and that it had become much worse recently. John told the GP that he had been sleeping in the car during the last day or so. The GP referred John to the Local Primary Mental Health Service (LPMHS) for counselling. The referral letter stated that Betty wanted him to cuddle her and to look after her, but that he was a private man and that he found it a difficult thing to do. The letter added 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 has been throwing things around the house and the police had been called. The police had suggested that they should both have counselling, but Betty had told the GP that the problem was with John and not with her.

Comment: *Although it is known that Betty and John saw the same GP on the same day, the practice records are not clear whether they were seen together or separately. As mentioned above, details of the conversations/emails between the practice manager and the CHC were documented in Betty's medical notes.*

LPMHS is a service for people with common, mild to moderate mental health problems such as anxiety, depression and stress. They offer a variety of services including mental health assessments and advice, support and signposting to other relevant services, stress management courses and a range of psychological interventions.

11.17 JULY 2018

John cancelled his appointment with the LPMHS that had been scheduled for mid-July, saying he did not require the service, but it is not recorded why he did not want it.

Comment: *John told the review Chair that he never wanted counselling for himself and that to have kept the appointment would have been a waste of everyone's time, adding that had he been able to facilitate a like appointment for Betty, he would have been delighted.*

11.18 NOVEMBER 2018

The GP's notes indicate that Betty had a consultation specifically about her stress and anxiety at home. The notes state: *'Have had some relationship difficulties but easing now'.*

Comment: *Betty was seen by a different GP on this occasion, but he/she should have been aware of Betty previously asking for help with her excessive drinking, threatening her husband and abusive behaviour because of the entry in her medical record about her contact with the CHC.*

11.19 DECEMBER 2018

John had a consultation with the Practice Nurse in December 2018, 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 and that the police being called to the house had exacerbated the situation. 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.

Comment: *This consultation took place only six months after the conversations/emails between the CHC and the practice manager. Betty and John were seen by different GPs in June and November 2018. The Safeguarding Lead is a different GP.*

11.20 John also had a consultation with a GP later in December, 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'. The GP also noted that there was a query that Betty may be getting early dementia.

Comment: *It is unclear from John's medical notes whether the suggestion of dementia came from him or if it was proposed by the GP following the consultation.*

11.21 ANALYSIS OF POLICE AND TRIAGE TEAM CONTACT WITH BETTY AND JOHN

11.22 The CPN from the Mental Health Triage Team who was asked by the police to visit Betty and John's home found no indication of Betty having a severe or enduring mental health problem that necessitated immediate action. Because there were no identified mental health (or alcohol) issues, the CPN had no reason to submit a risk-assessment or make any referrals to support agencies and the police did not complete a Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification Checklist (DASH risk-assessment)[26] or a Multi-Agency Referral Form

[26] https://safelives.org.uk/practice-support/resources-identifying-risk-victims-face#:~:text=When%20someone%20is%20experiencing%20domestic,help%20as%20quickly%20as%20possible.&text=Dash%20stands%20for%20domestic%20abuse,extensive%20research%20of%20domestic%20abuse.

(MARF)[27] because they did not have any concerns that either Betty or John was at risk of significant harm.

Comment: *DASH risk-assessment questions are based on extensive research of domestic abuse. The aim is to make an accurate and fast assessment of the danger a person is facing, so the right help may be provided as quickly as possible.*

Nowadays, Dyfed-Powys police policy is that all 'domestic incidents' (including verbal arguments) require the submission of a DASH risk-assessment, so a similar incident happening today would result in one being recorded.

A MARF can be submitted to the Local Authority for social care and support by any agency about anyone who is at immediate risk of significant harm.

11.23 ANALYSIS OF THE CONTACT WITH THE GP PRACTICE

11.24 The GP Practice say that at the time they were not aware of what support services were available locally for victims or perpetrators of domestic abuse, but that they now have access to resources such as the Live Fear Free Helpline[28], the DASH risk-assessment checklist and the Multi-Agency Risk-assessment Conference (MARAC)[29] referral processes and to the Older Person's Commissioner leaflets about domestic abuse[30] and the Regional VAWDASV Pathway to support document. They are also now aware that they can contact the Health Board corporate safeguarding team should they need safeguarding advice.

Comment: *A MARAC is a meeting where information is shared on the highest-risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors. After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. The MARAC will also make links with other fora to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.*

11.25 However, while seeking help for Betty with her mental health difficulties, John disclosed information (on more than one occasion) that should have indicated at the very least that he was potentially a victim of domestic abuse and that Betty was the perpetrator of it. Betty took what must have been a massive step for her in telephoning the CHC. She told them she wanted to track-down the mental health nurse who had been to her house and that she was being aggressive to her husband, that she was 'Smashing up the house' and that she was drinking all day. The CHC went out of their way to make sure the information had been properly

[27] https://www.carmarthenshire.gov.wales/media/1212381/guidance-on-completing-a-pova-form.pdf
[28] https://gov.wales/live-fear-free
[29] https://www.gov.uk/government/publications/multi-agency-risk-assessment-conference-marac-protection-plans-requests-for-evidence
[30] https://olderpeople.wales/?s=leaflet&t=resource

noted by the GP Practice, but nevertheless, Betty was never spoken to about it by anyone there, even though she was seen by a GP only a few days later. These were clear opportunities missed to support both Betty and John, irrespective of any lack of knowledge of what domestic abuse support services might have been available at the time.

12. ADDRESSING THE TERMS OF REFERENCE

12.1 Each term appears in bold italics and is examined separately. Commentary is made using material from the Individual Management Reviews, information gleaned from people interviewed during the review and the domestic homicide review panel's discussions. Some material would fit into more than one term and where that happens a best fit approach has been taken to avoid unnecessary duplication.

12.2 ### Term of reference (TOR) 1

- ***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.***

12.3 There is no known history or evidence that John had been physically violent towards Betty previously, so in that context, the incident in which Betty died was very much an isolated one.

12.4 Although the police, the GP Practice, the CHC and friends and neighbours were aware of instances when Betty had apparently been verbally abusive towards John, there were no warning signs that he was likely to react violently to it. Those who knew him well say his way of coping with confrontation with Betty was simply to walk away from it.

12.5 ### TOR 2

- ***Whether more could be done locally to raise awareness of services available to victims of domestic abuse, especially for older people.***

12.6 Awareness raising of services available to victims of domestic abuse specifically within the GP Practice is discussed in TOR 4 below.

12.7 The review panel is mindful that raising awareness of domestic abuse should be a constant process and that it needs to be targeted to the wider community as well as to professionals. This review has specifically highlighted the need to raise awareness 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 acknowledge 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 is 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.

12.8 **TOR 3**

- ***Whether 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.***

12.9 The evidence is that John was focussed completely on Betty's mental well-being. When asked about his understanding of domestic abuse, he said he had always thought of it in terms of physical violence committed by a husband upon his wife. John said he therefore never considered himself a victim of domestic abuse nor did he think for a moment that Betty might have been a perpetrator of it. A barrier to his reporting of it therefore was his lack of understanding of what constitutes domestic abuse.

12.10 John said that talking to other people about the problems he was experiencing at home was difficult and embarrassing and that his nature made it extremely hard for him to ask for and to accept help. He added that his generation tended to 'Just get on with things', as opposed to asking other people for help, and that even had he realised he had been the victim of domestic abuse, his upbringing and ingrained attitudes would in all probability have acted as a barrier to him reporting it.

Comment: *In a study on domestic abuse and older women[31], participants spoke of how historically the home was perceived as private and 'What went on behind closed doors stayed there.' Study participants also felt a sense of shame or embarrassment and as such kept their experiences 'Hidden' from family, friends and neighbours.*

12.11 This report identified earlier that some older people may be less aware than younger people of services and options available to them (not just in respect of domestic abuse), or they may believe that services are only for younger people, or people with young children. John told the review Chair that he did try researching how he could get help for Betty in respect of her mental ill-health and that he had looked through the telephone directory and had searched the internet. He said he cannot now recollect what telephone number he dialled when he thought he was contacting mental health services and inadvertently contacted the police, nor where he had found the telephone number.

12.12 It is not known how or where Betty found the CHC telephone number when she decided to track-down the CPN, but she must have overcome significant barriers within herself to have even attempted to do so. For an elderly, independent and strong person it must have been difficult enough, but it was also against a backdrop of Betty's previous assertions that she did not need help and that any problems she was experiencing were caused by John. The CHC returned Betty's

[31] McGarry, J. and Simpson, C (2011). *Domestic abuse and older women: exploring the opportunities for service development and care delivery.* The Journal of Adult Protection Vol 13 No 6.

calls and asked her for permission to tell her GP what had happened. Betty agreeing for that to happen must have been another momentous step for her to have taken, but the fact that GP Practice then did not even raise the subject with her during a consultation only a few days later must have been immensely demoralising for Betty and must have created an additional barrier to her making any further disclosures.

12.13 It is known from research that there are significant additional barriers to reporting domestic abuse in rural communities compared to urban areas[32], for example, the availability of public services in rural areas more generally are reported to be on the decline and victims were clear that domestic abuse support services were much harder to find and much harder to engage with than in an urban setting. The same research also identified isolation from friends and from family to be a significant factor (although the emphasis of the report was on the isolation being used as a tool of abuse by a perpetrator). That was not the case with Betty and John, but nevertheless they did lead a relatively isolated lifestyle, albeit it was of their own design. They lived in quite a remote village, they tended to keep themselves to themselves (Betty more so that John), and neither had any close family members. John was friendly with some local people and had a small social network, but in comparison, Betty did not, so their isolation, in particular Betty's, must have acted as a barrier to them accessing services.

12.14 The friends and neighbours who kindly participated in this review did not know Betty very well because she chose to keep herself to herself. They were aware that John was very worried about Betty's mental health and they gave him advice as best they could, including that he should speak to his and Betty's GP and if necessary, to the police. They had no real reason to consider domestic abuse or domestic abuse services because as far as they were concerned, the issues were all to do with Betty's mental ill-health, so the question in their minds of reporting domestic abuse never arose.

12.15 **TOR 4**

- ***Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Betty and John that were missed.***

12.16 The review panel did not see any evidence that professionals recognised domestic abuse in the relationship between Betty and John, except for the CHC who took Betty's telephone calls very seriously and did their best to prompt immediate action by the GP practice. Research by the Dewis/Choice Project[33] asserts that professionals 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, so it is important that practitioners do not stereotype

[32] https://crimestoppers-uk.org/news-campaigns/news/2017/sep/domestic-abuse-in-rural-communities
[33] https://dewischoice.org.uk/what-we-do/research/projects-at-centre/current-projects/

or make judgments in relation to older people and that they explore all potential experiences of older people in transparent and open-minded ways.[34]

Comment: *The Department of Law and Criminology at Aberystwyth University led the Dewis/Choice Project. This research involved a longitudinal study about older people's experiences of seeking help in Wales for domestic abuse. The published research covers barriers in older people accessing support and how services appear to them.*

12.17 The VAWDASV 'Ask and Act' framework in Wales advocates targeted as opposed to routine enquiry. Targeted enquiry involves relevant professionals applying a 'Low threshold for asking' whether the patient is experiencing domestic abuse when the patient presents with certain indicators of abuse. The targeted enquiry can also be applied to perpetrators of domestic abuse.

12.18 There were attendances at the practice by both Betty and John with mention by John of him being abused by Betty and of course the practice received telephone calls and emails from the CHC about Bettys conversations with them which were followed in mid-June 2018 by Betty telling her GP that she had been drinking more and that she blamed it on John. Then in November 2018, the GP recorded that Betty had stress at home and general anxiety. The following month, during a consultation with the Practice Nurse, John said that Betty was being abusive and was smashing objects in the home. It was recorded that John was also concerned that Betty could end up throwing boiling water or hot fat out of temper. The records state, *"Have had some relationship difficulties, but easing now".* Later that month, John told his GP that Betty had been violent and angry during the previous two weeks. The GP practice recall that Betty would often begin to talk about her relationship and then 'back-track' on what she said. The GP described feeling frustration when Betty would not fully disclose what was going on with her. Yet, despite all this, no targeted enquiry was ever made of Betty (or John) about domestic abuse.

12.19 The DHR panel has noted that the Safeguarding and Access to Justice Lead at the Older Person's Commissioner Office delivered domestic abuse and older people training in Hywel Dda University Health Board (HDUHB) in 2016 and 2019, but that Betty and John's GP practice had not been aware of it. In addition, although the corporate safeguarding team actively promote the Live Fear Free helpline, the Practice Nurse did not know about it either. There is an obvious need therefore for an improvement in the Health Board's links with GP practices to ensure they are aware of their responsibilities and what resources are available to them to provide support, not just to older people, but everyone in the community who may be affected by domestic abuse.

12.20 Resulting from a different DHR within the region, the Head of Safeguarding has worked with the Regional VAWDASV Advisor to put together a proposal to implement a pilot of IRIS in a GP cluster. The aim is to increase early recognition of

[34] Wydall, S., Zerk, R. Newman, J. 2015. Crimes against, and abuse of, older people in Wales: Access to support and justice working together. Report submitted to Older People's Commissioner for Wales. Available at: https://dewischoice.org.uk/

abuse in primary care to promote appropriate referrals and signposting. Three GP clusters in another county have expressed a desire to participate in the pilot which has now been fully funded by the Health Board. The pilot will be fully evaluated and learning from it will be used to inform implementation of the IRIS i programme within Ceredigion.

Comment: *The IRISi[35] (Identification and Referral to Improve Safety) programme is a training, referral and advocacy model to support clinicians to better support their patients affected by domestic violence and abuse and to increase awareness of it within general practice. IRIS provides specialist training to clinical professionals and administration staff within local GP surgeries. Its training supports clinicians to recognise and respond to patients affected by domestic violence and abuse and provides a direct referral route to a named advocate in a local specialist domestic abuse service.*

IRIS+ aims to explore the viability of an adaptation of IRIS to work with both male and female victims, male and female perpetrators and children. IRISi acts as a consultant on this project, advising around the development of the training materials and its delivery to clinicians. A revised intervention is being carried out in Bristol and Cardiff and will be fully evaluated in due course.

12.21 In addition, all GP practices in the region have been made aware of their responsibilities in relation to recognising domestic abuse and taking appropriate action via a letter from the Health Board Associate Medical Director, including completion of the Risk Indicator checklist and consideration of referrals to MARAC.

12.22 GP Practices have also been advised about how to access the Dewis Choice training and have been sent details of the practitioners' guide. A recommendation has been made to the Regional VAWDASV Communication Subgroup that the 'Transforming the Response to Domestic Abuse in Later Life Practitioner Guide' should be published in summary form for ease of reference for practitioners. The Welsh Government VAWDASV Good Practice Guidance for Non-specialist Welsh Public Services on Working with Adult Perpetrators has also been distributed to GP practices and is available on the Health Board safeguarding intranet site.

12.23 GP practices have also been made aware of how to access safeguarding and 'Ask and Act' training and have been advised about how to access resources for patients and professionals, including the Live Fear Free helpline. Primary care services are reviewing how they can monitor compliance with training in these contracted services and the Health Board has appointed a Lead VAWDASV and Safeguarding Practitioner who will work to improve links with primary care. More recently, GP practices have been provided with Regional GP Pathfinder guidance.

Comment: *Whilst the Welsh Government fund regional consortia to deliver 'Ask and Act' training, which is made available to all GP practices, there remains barriers in places*

[35] https://irisi.org/

around funding IRIS. Welsh Government have previously indicated that funding IRIS is not seen as a priority, despite well evidenced outcomes of its success in primary care.

12.24 **TOR 5**

- ***Whether there were opportunities for agency intervention in relation to domestic abuse regarding Betty and John that were missed.***

12.25 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. Thresholds for referrals to other agencies were significantly short of being met.

12.26 The GP Practice on the other hand certainly did miss opportunities for agency intervention and with the benefit of hindsight, they acknowledge they should have done more and accept that a significant issue then was that they were not sufficiently aware of the nature of domestic abuse services that were available nor of pathways to support.

12.27 **TOR 6**

- ***Whether alcohol abuse was a factor in the relationship between Betty and John, whether agencies knew about it and if so, what could have been done to intervene?***

12.28 Betty's medical records indicate that many years ago she was described as a heavy drinker, then in 2016 she was teetotal and a year later she was an occasional drinker. When Betty contacted the CHC two days after John had inadvertently called the police to their home in June 2018, as well as saying she was being aggressive towards John and that she was damaging the house, she said she was drinking all day. When she saw the GP a few days later, she also disclosed that she had been drinking more, blaming it on her husband (there was apparently no explanation sought by the GP as to what she meant by it being John's fault). No support was offered to Betty about her alcohol use and there was no further mention of her alcohol intake at subsequent consultations with the GP (The Dyfed Drug and Alcohol Service has told this review they would have expected at least a brief intervention conversation with Betty about support services and that John could have been offered 'Concerned Other' support).

12.29 There has been no suggestion that John used alcohol to excess or that when he did have a drink at the local pub with friends, it had an adverse effect on his relationship with Betty.

12.30 **TOR 7**

- ***Whether anyone considered Betty to have been at risk of harm and whether those concerns were shared and acted upon.***

12.31 No one thought that Betty was at any risk of harm from John and there is nothing to suggest that Betty did either.

13. AGENCY LESSONS LEARNED

13.1 Everyone involved in this review appreciates 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.

13.2 There is 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 are also key lessons learned. Even had appropriate support about domestic abuse been offered to John, there is little doubt he would have refused it because he did not identify as being a victim. When working with older people therefore, broader questions should be broached in the first instance around topics such as challenges in relationships, before progressing to more targeted discussions around potential domestic abuse.

Comment: *Work is already ongoing through VAWDASV in light of the identified need to improve regional practice around responses to domestic abuse involving older people. They have developed specific DHR learning materials including sessions on rurality, male victims and older victims which are intended to improve practice, increase professional curiosity and re-enforce links to specialist support providers across the Mid and West Wales region*

13.3 The Regional Partnership are working with survivors across the region to build upon survivor engagement and a communication framework. The intention is to engage with all communities across Mid and West Wales and to use it to inform and improve practice and service design. They have also engaged Dewis Choice in the work to ensure the voices and experiences of older victims are included.

13.4 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 and as mentioned at TOR 4 above, a lot of work is being undertaken in this regard.

13.5 Also mentioned at TOR 4 is that GP Practices have been reminded about how to access the Dewis Choice training and have been sent details of the Practitioners' Guide, together with the guidance for Non-specialist Welsh Public Services on Working with Adult Perpetrators.

13.6 A new All-Wales DASH Risk Identification Checklist (RIC)[36] has helped formalise a process to explore a patients' reason for consulting a GP and to consider the wider implications with a structural analysis of safeguarding training being undertaken by Health Board staff to ensure all employees are trained to an appropriate level.

Comment: *This has been discussed on a regional basis and it has been agreed that a review of the DASH Risk-assessment process will take place in collaboration with academic research and with domestic abuse survivors to ensure that risk is assessed in their best interests.*

14. CONCLUSIONS

14.1 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.

14.2 Evidence provided by people who were close to Betty and John is that Betty would sometimes be aggressive towards John for no apparent reason, that she bullied him and that it happened more frequently in recent years. They all say that John was becoming increasing worried about Betty's mental health.

14.3 John never considered himself the victim of domestic abuse and to this day disagrees with any suggestion that Betty bullied him. He sought support from the police and from his GP about Betty's mental health predicament, and in doing so he disclosed information that should have triggered concerns that he might have been a low-level victim of coercive and controlling behaviour. Betty took the brave step of reaching out for help when she telephoned the CHC, but although the information was passed to her GP Practice, nothing was done about it.

14.4 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 (and John) were independent adults who had the right to autonomy in their own decision-making.

[36] https://www.scie-socialcareonline.org.uk/all-wales-risk-identification-checklist-ric-and-quick-start-guidance-for-domestic-abuse-stalking-and-honour-based-violence/r/a11G000000AxPCSIA3

14.5 The Older People's Commissioner for Wales 'State of the Nation' - An overview of growing older in Wales (2019)[37] 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 data set that provides a complete picture of the scale and type of abuse experienced by older people in Wales.

14.6 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[38]. 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[39] (Helping others participate and engage), a partnership project between Age Cymru, Age Cymru's local partners and Age Connects Wales partners which is funded by Welsh Government under the Sustainable Social Services Grant until the end of March 2023, is now delivering advocacy for older people (50+) and carers across Wales. A recommendation from this DHR is that the CSP will maintain contact with these initiatives to ensure they are fully exploited in the Ceredigion region.

15. RECOMMENDATIONS

15.1 Generic and agency-specific recommendations can be found below. The timescales within which they are to be achieved and who will be responsible for their implementation are detailed within the action plan that accompanies this report.

15.2 ### CEREDIGION COUNTY COUNCIL

15.3

- *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*

[37] https://olderpeople.wales/resource/state-of-the-nation-2019/
[38] https://www.olderpeoplewales.com/en/stopping-abuse/action-group.aspx
[39] https://www.ageuk.org.uk/cymru/

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.*

15.4 DYFED-POWYS POLICE

15.5

- *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.*

15.6 HYWEL DDA UNIVERSITY HEALTH BOARD

15.7

- *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 OVERVIEW REPORT