DOMESTIC HOMICIDE REVIEW - OVERVIEW REPORT

Dorset Community Safety Partnership

Report into the death of JANE

June 2022

Report produced by Simon Steel – Perse Perspective Consultancy Ltd

Report Completed on 30/11/2023

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The following tribute has been prepared by the family of Jane and David.

"We dearly miss you both.

You continue to touch our lives with fond memories, your kindness and your enthusiasm of all thing's nature.

Especially.... for your love of birds and beautiful photography of which we treasure.

And ..... for your love of the countryside and your many creative skills of which we also treasure."

Foreword

The Dorset Community Safety Partnership would like to express their condolences to all those affected by the sad loss of Jane and David. The independent chair of this Domestic Homicide Review panel would like to thank all agencies who contributed to the process in an open and transparent manner. The panel would also like to thank those family and friends who contributed to this review.

1. Introduction

1.1 This Domestic Homicide Review (hereafter "the review") was established under Sec 9(3) of the Domestic Violence Crime and Victims Acts 2004. It examines agency responses and support given to Jane who was a resident of Dorset prior to her death in June 2022.

1.2 On the day of her death Police and other emergency services attended, and Jane was pronounced dead at the scene. Also, her husband David was pronounced dead at the scene. Enquiries at the scene led to the belief that there was no third-party involvement, and the case was passed to HM Coroner.

1.3 The review will consider the contact and involvement that services had with Jane and David for 2 years prior to their deaths. The review will examine how agencies worked individually and collectively with Jane and David. In addition to involvement of services, the review will also examine the past to try and identify any relevant background prior to the deaths and whether support was accessed within the community. By taking this holistic approach, the review attempts to identify opportunities for improved responses that will make the future safer.

1.4 The key purpose for undertaking reviews of this nature is to enable lessons to be learned from deaths which occur in similar circumstances and with a related background. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to

understand, fully, what happened following each death, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.5 This review process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.6 The review panel wishes to express its deepest sympathy to the family and friends of Jane and David, for their loss and thank them for their contributions and support for this process.

2. Timescales

2.1 Dorset police referred this matter to the Dorset Community Safety Partnership (CSP) on the 6th of July 2022. Following an initial scoping of the referral contact was made with the Home Office on the 5th of August 2022. For a number of months there was ongoing contact with the Home Office, who wrote to the Leader of the Council in February 2023. On the 6th of March 2023 the leader of the council responded confirming the Partnership would carry out a Domestic Homicide Review into this matter.

2.2 Simon Steel was commissioned to provide an Independent Chair (hereafter 'the chair') for this review on the 20th of April 2023. The completed report was passed to the Community Safety Partnership (CSP) on 21 December 2023. It was submitted by the CSP to the Home Office Quality Assurance Panel on 26 January 2024.

2.3 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was slightly extended to allow a thorough review to take place in line with the home office guidance.

3. Confidentiality

3.1 The findings of this review are confidential and will remain so until the Overview Report and Executive Summary have been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating professionals/officers and their line managers.

3.2 Details of confidentiality, disclosure and dissemination were discussed and agreed between member agencies during the first panel meeting and all information was treated as confidential and nothing was disclosed to third parties without the agreement of the responsible agency's representative. Each agency representative was personally responsible

for the safe keeping of all documentation that they possessed in relation to this review and for the secure retention and disposal of that information in a confidential manner.

3.3 It was recommended that all members of the Review Panel used a secure email system, and that information should not be sent in any other way and was also password protected.

3.4 This review has been suitably anonymised in accordance with the statutory guidance. The pseudonyms were provided by Peter (David's brother) and are used in the report to protect the identity of the individuals involved.

Pseudonym	**Relationship**	**Age at the time of the incident**	**Ethnicity**
Jane	Deceased	76	White-British
David	Deceased (Husband)	79	White-British
Peter	David's brother	78	White-British

3.5 As per the statutory guidance, the chair, author, and the review panel members are named, including their respective roles and the agencies which they represent. Agencies that provided information are also identified.

4. Terms of Reference

4.1 Following discussions at initial panel meetings the chair circulated the Terms of Reference (TOR), to the agencies that had contact with Jane and David. Details of the Terms of Reference are contained in Appendix 1. The review aims to identify learning from Jane's death and for actions to be taken in response of that learning with a view to preventing similar deaths and ensuring that individuals and families are appropriately supported in the future.

4.2 The review panel comprised of agencies from the Dorset CSP, as Jane and David lived in their area at the time of her death. They were contacted as soon as possible after the review was established to inform them of the need to identify and secure records and for their participation within this process. All panel members were independent from the case or line management of anyone from their agency who had interactions with Jane and David.

4.3 Key Lines of Enquiry: During the review the chair and panel have considered both the 'generic issues' as set out in the generic guidance and additional issues specifically relevant to this case. Various discussions have led to the following case specific issues being agreed.

1. Were there any concerns or reports made by family, friends, or neighbours about the vulnerability of the victim to abuse. Were opportunities missed to explore these?
2. Were there any barriers to services experienced by the victim or her family and friends, in reporting concerns, specifically any relating to abuse? How could these have been reduced?
3. Did Covid-19 impact on the ability of the hospital to satisfactorily engage with, understand and respond to the victim when assessing her vulnerability and any potential abuse. Could more have been done with the information available?
4. Did Covid-19 impact on the ability of the GP to satisfactorily engage with, understand and respond to the victim specifically in respect to the potential for identifying vulnerability and abuse. Could more have been done with the information available?
5. The shotgun license and process around assessing vulnerability and that of wider family.

4.4 At the initial panel meeting agency members shared a summary of their engagement that they had with Jane and David. At this early stage it was apparent that there was very little contact Jane and David had with agencies. As a result, it was agreed that the time focus for this review would be from 2 years before Jane's death. This period was chosen to allow for an in-depth review of current methods and processes to be carried out and to ensure that recommendations and learning would be based on existing policies, procedures, and training. The timescale was proportionate with the information the scoping had identified and nothing further was identified to suggest the scope needed extending. Where appropriate, information about the relationship outside of this period has been included to provide context.

5. Methodology

5.1 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse This review commenced after the Domestic Abuse Act receiving royal ascent in April 2021 and defines domestic abuse as:

- The Behaviour of a person (A) towards another person (B) if.

    I. A and B are each aged 16 or over and are personally connected to each other and.

    II. The behaviour is abusive.

- Behaviour is abusive if it consists of any of the following -

    1. physical or sexual abuse.
    2. violent or threatening behaviour.

3. controlling or coercive behaviour.
4. economic abuse (see subsection 4).
5. psychological, emotional, or other abuse.

It doesn't matter whether the behaviour consists of a single incident or a course of conduct.

Two people are Personally Connected to each other if any of the following applies.

1. They are, or have been, married to each other.
2. They are, or have been, civil partners of each other.
3. They have agreed to marry one another (whether or not the agreement has been terminated).
4. They have entered into a civil partnership agreement (whether or not the agreement has been terminated).
5. They are, or have been, in an intimate personal relationship with each other.
6. They each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection 2).
7. They are relatives.

It is defined as any incident or pattern of incidents of controlling, coercive or 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. This can encompass but is not limited to the following types of abuse, psychological, physical, sexual, financial, and emotional.

5.2 Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

5.3 Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

5.4 This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation and forced marriage and is clear that victims are confined to one gender or ethnic group.[1]

[1] https://www.gov.uk/government/news/new-definition-of-domestic-violence

5.5 This review has followed the statutory guidance. On notification of the death, agencies were asked to check for their involvement with any of the parties concerned and secure their records. It was during this scoping process that chronologies were collated and combined. This overview was reviewed by the chair and Individual Management Reviews (IMRs) for 3 agencies that had contact with Jane or David were requested. IMR's were prepared by Dorset Police, the Integrated Care Board (ICB) for the GP, and the Dorset County Hospital NHS Foundation Trust.

5.6 Document Reviewed

In addition to the combined chronology and IMR's, various documents and open-source research has been carried out including:

- Website for commissioned service for domestic abuse support.
- Home Office Documents referring to key findings from analysis of previous DHR's.
- Citizens Advice document regarding "What is Public Sector Equality Duty".
- Dorset CSP website – Domestic Homicide Review.
- Screening women for inter-partner violence in healthcare settings (Review), Cochrane Library 2015.
- The Royal College of Nursing – Roles and Responsibilities of Health care staff.
- The Care Quality Commission (CQC) report on the relevant GP Surgery.

The panel actively and extensively sought information from a wide range of potential contributors/services, to ensure nothing was missed.

5.7 Panel Meetings

Review Panel meetings took place on 21st June 2023, 2nd August 2023, 4th October 2023 and the 30th of November 2023. The chair held individual agency discussions with panel representatives, and authors to seek clarification on points within agency IMR's and review Key Lines of Enquiry.

6. Involvement of Family, Friends, Work Colleagues, Neighbours, and Community

6.1 Following the decision to conduct a DHR the Partnership wrote to the family, details of contact with the family are at Appendix 3.

6.2 The chair made efforts to engage with Jane's sister however she decided she did not wish to take part in this review.

6.3 The chair engaged with Peter, David's brother, and Jane's brother-in-law. The chair met Peter along with his wife on 2 occasions at a location requested by Peter. Advocacy after Fatal Domestic Abuse (AAFDA) supported Peter and were present at the second in person meeting. The TOR were discussed with the family, and they were in agreement that the panel had

addressed all the concerns they wished to explore. When the draft overview was ready the chair delivered it in person along with AAFDA on the 21st of November 2023. The draft was left with the family who then had time to consider the contents. Subsequently they confirmed with AAFDA that they were content with the draft overview.

6.4 Peter explained to the chair that David was his older brother and that they had grown up together on the family farm. Later in life David had run a butcher's shop. He described how David and Jane had a good marriage and did many things together, albeit both had their separate interests. Around 20 years ago they took early retirement and moved to Dorset to retire their together. He was not aware of any issues within the marriage and described them as a loving couple. Throughout his life he described David as having had access to firearms, whether this was on the farm, or when he was involved with working dogs on shoots. Understandably this tragic incident has had a profound impact on Peter, and he cannot understand why this has happened. He raised a concern around the shotgun that David had, stating that he thought he had given up shooting as he had a bad knee and did not keep the gundogs anymore.

6.5 2 friends of Jane and David spoke with the chair by their preferred method of telephone communication. The chair did offer in person visits but both where content with telephone contact and email. The first friend spoken to stated she had known Jane and David for around 15-20 years. She described them as a loving happy couple. She last saw both of them the day before their deaths. When she saw Jane on that day she described her as looking grey and she still looked very poorly, and she believed that Jane should still have been in hospital and not discharged.

6.6 She stated that when she saw David on the Saturday when Jane was in Hospital (the day before her discharge.) David was still unsure when Jane was coming home. She describes David as having to do everything for 3 weeks leading up to their deaths and he was struggling. David always wore shirts which were ironed by Jane, and she then took over ironing his shirts to help out. She describes when Jane initially went to the GP with concerns for her health, Jane told her that she was told it was muscular.

6.7 She was aware that David used to be a gamekeeper, but raised the question on why he still had the shotgun, and why was his license renewed around a year before the deaths when he was no longer shooting. However, she did say he was still going out on the odd shoot just not very often. She considered whether David could live without Jane.

6.8 Another friend said that she had known Jane and David for 23 years. She knew Jane better as David was not as social as Jane. She also stated that Jane should not have been discharged from the hospital. She also saw both of them on the Monday and concluded that Jane did not look well at all. She also raised concerns around the shotgun that David had stating that he had given up shooting some years before.

6.9 She described an incident in the month before the deaths when David went round her house and showed her his tongue. She described it looking like a yellow ulcer. She told him he should see his GP. She also told Jane he should see a GP about it.

7. Contributors to the Review

7.1 The following agencies and the contributions to this review are:

Agency	Contribution
Dorset Police	Chronology & IMR
NHS Dorset Integrated Care Board (on behalf of the GP)	Chronology & IMR
Dorset County Hospital NHS Foundation Trust.	Chronology & IMR
South West Ambulance Service	Chronology & Short Report

7.2 Quality and Independence of the IMR authors. The IMR's were prepared by authors who were independent of any service delivery or case management regarding Jane or David. The IMR's were comprehensive and allowed the panel to analyse the contact with Jane and David. The detail ensured that the panel were able to identify learning and recommendations for this review and where necessary, follow-up meetings were held, and questions sent to agencies. Responses were received, prior to, or at, subsequent panel meetings.

8. Review Panel Members

Name	Role/Job Title	Agency
Simon Steel	Independent Chair and Author	Perse Perspective Consultancy Ltd
Stewart Balmer	Force Review Officer	Dorset Police
Kirsten Bland	Designated Professional for Adult Safeguarding	NHS Dorset

Sarah Cake	Head of Safeguarding / Directorate of Nursing and Quality	Dorset County Hospital NHS Foundation Trust
Alison Clark	Head of Safeguarding	Dorset Healthcare University NHS Foundation Trust
Joe Ennis	Deputy Head of Service for Dorset, Devon and Torbay	Probation Services
Diane Evans	Community Safety Business Manager	Community Safety Partnership, Dorset Council
Karen Maher	Strategic & Operational Lead	Adult Safeguarding, Dorset Council
Tonia Redvers	Director of Paragon, Young Lives and Counselling	The YOU Trust
Jane Stuart	Principal Social Worker	Children Social Care, Dorset Council
Neil Wright	Chief Inspector - Safeguarding Hub	Dorset Police
Andrea Breen (Panel Aug 23)	Head of Specialist Services	Adult Social Care, Dorset Council

9. Author of the Overview Report

9.1 Simon Steel was appointed by the Community Safety Partnership as Independent Author of this Domestic Homicide Review panel. Simon is a retired Thames Valley Police senior Detective. He has considerable experience in the field of domestic abuse, Public Protection and Safeguarding. His experience includes specialist, strategic and generic investigative roles across the Thames Valley. Simon has also led complex Domestic Homicide Investigations.

9.2 Since retirement, Simon has established his own consultancy business and has now chaired numerous Domestic Homicide Reviews. Simon has been subcontracted by Foundry Risk Management who have a long history of chairing reviews, and a history of subcontracting Simon.

9.3 Simon has also worked as the Head of Adult Support for an autism charity within the voluntary sector who are commissioned by local authorities and Integrated Care Boards (ICB). Simon has also worked as a Learning Disability and Autism Champion for an ICB. Simon believes his work alongside statutory, non-statutory and voluntary sector organisations provides him an enhancement to his policing portfolio.

9.4 Simon has completed Home Office approved Training and has attended subsequent Training by Advocacy After Fatal Domestic Abuse.

9.5 Simon has no connection with the Dorset Community Safety Partnership, or any of the agencies involved in this review.

10. Parallel Reviews

10.1 Inquest: The coronial hearing in this case took place on the 19th of June 2023. It recorded that Jane died by a gunshot wound inflicted by another, and that David died by suicide.

11. Equality and Diversity

11.1 The review panel considered all 9 protected characteristics under the Equality Act 2018 i.e.

- Age
- Disability
- Gender Assignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation.

11.2 The panel reflected upon each of these in evaluating the various services provided to Jane. It is incumbent on this review to consider the duty on public authorities[2] to; remove or reduce disadvantages suffered by people because of a protected characteristic, meet the needs of people with protected characteristics, encourage people with protected characteristics to participate in public life and other activities.

11.3 Each protected characteristic was analysed by both individual agencies and the panel, against policies and procedures that were in place at the time of the death of Jane. There were a number of protected characteristics that the panel agree are pertinent to this review. These include examining the circumstances through the lenses of sex and age.

11.4 The panel identifies that women and girls are disproportionally impacted by domestic abuse and other forms of gender-based violence and abuse. Analysis reveals gendered victimization

[2] https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/

across both intimate partner and familial homicides with females representing most victims and males representing most perpetrators.

11.5 SEX: Jane was female, and her husband was male. The gendered nature of domestic abuse is evidenced and recorded in a number of reports and also by specialist organisations. An analysis of DHRs [3] reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators. Women's Aid reports[4], "There are important differences between male violence against women and female violence against men, namely the amount, severity, and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2020A; ONS, 2020B)."

11.6 AGE: Safelives[5] report on average, older victims experience abuse for twice as long before seeking help as those aged under 61 and nearly half have a disability. Yet older clients are hugely underrepresented among domestic abuse services.

11.7 Within the report safe later lives[6] it is identified that many of the problems facing older victims are common to all of those experiencing domestic abuse. However, older victims' experiences are often exacerbated by social, cultural and physical factors that require a tailored response. The Insights dataset shows that clients over 60 are less likely to have attempted to leave than those under (17% vs 29%).

11.8 It is against the background of concerns raised in such reports, that the review will consider the circumstances of Jane's death.

12. Dissemination

12.1 Once finalised by the Review panel the Executive Summary and Overview Report will be presented to the following CSP panel members for approval. Upon approval they will be sent to the Home Office for Quality Assurance.

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[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

[4] Domestic abuse is a gendered crime - Womens Aid

[5] Spotlight #1: Older people and domestic abuse | Safelives

[6] Spotlight #1: Older people and domestic abuse | Safelives

12.2 The recommendations will be owned by Dorset Community Safety Partnership, who will be responsible for disseminating learning through local professional networks as well as managing progress of the Action Plan which is created at the conclusion of this review and in response to the recommendations that have been made.

12.3 The following individuals and agencies have been identified as recipients of both reports.

Agency
Pan-Dorset Safeguarding Children Partnership
Safeguarding Adults Board
Multi-Agency Domestic Homicide Review Oversight Group
The Family
All Panel Members

12.4 The report will be published online, on the Dorset CSP website.

13. Background Information (The Facts)

13.1 At the time of deaths both Jane and David were living together in their own home. Jane was 76 years old, and David was 79 years old.

The Death

13.2 On the morning of their deaths in June 2022 Jane and David were discovered deceased at their home address, nobody else lived at that address. Emergency services attended the address and Jane and David were pronounced dead at the scene. It was clear they had both died of gunshot wounds. From the CCTV at 06:02hrs that day a single shot can be heard on the rear camera. The time shown on the screen is 06:02:50. At 06.03hrs David called the police on 999 to report that Jane had died of a suspected heart attack and asked for police to attend straightaway. Police have the call received at 06:03:51. At 06:07hrs from the CCTV a further single shot can be heard on the front garden camera. The time shown on the screen is 06:07:07.

13.3 The Police investigated and concluded no third-party involvement, and the case was passed the case to HM Coroner. The coronial hearing in this case took place on the 19th of June 2023. It recorded that Jane died by a gunshot wound inflicted by another, and that David died by suicide.

Background information

13.4 The relationship between Jane and David had no recorded domestic abuse incidents from any agency or any reason to suspect any domestic abuse within the relationship. They had been married for over 50 years and had lived at that address for around 20 years.

14. Combined Narrative Chronology

14.1 The following section summarises contact between Jane and David and various agencies. To assist the reader, the table below summarises the names of the organisations and their role in this case. The paragraphs within the narrative chronology are prefaced with the lead agency to identify the primary source of information and assist the reader.

Organisation	Role	Acronym
Dorset Police	Police	Police
NHS Dorset Integrated Care Board (on behalf of the GP)	Primary Care	GP
Dorset County Hospital NHS Foundation Trust.	Hospital	Hosp
South West Ambulance Service	Ambulance	SWAST

14.2 July 2019

14.2.1 **GP.** David has 2 encounters this month for routine appointments to monitor blood pressure (BP) and his annual Diabetes review.

14.3 September 2019

14.3.1 **GP.** On the 12th Jane had a face-to-face appointment with her GP regarding her BP management.

14.4 November 2019

14.4.1 **GP.** During this month both Jane and David received their flu jabs at different times.

14.4.2 **HOSP.** On the 7th David was taken to hospital and admitted with back, chest and abdominal pain. He was subsequently discharged and had a follow up with his **GP** on the 19th.

14.5 March 2020

14.5.1 **GP.** On the 5th David saw his GP for pain in his feet walking.

14.6 April 2020

14.6.1 **GP.** During this month David was seen and there were some concerns from his GP of potential heart disease given nature of his presentation. He was referred to the rapid access chest pain clinic. No heart disease was detected.

14.7 September 2020

14.7.1 **GP.** David has 2 encounters this month for his annual Diabetes review, a cough and plantar fasciitis.

14.8 October 2020

14.8.1 **GP.** On the 1st both Jane and David had their flu jabs.

14.9 February 2021

14.9.1 **GP.** On the 16th Jane saw her GP for blood pressure management and blood tests.

14.10 May -August 2021

14.10.1 **GP.** David had 3 appointments regarding knee pain and treatment and also received a letter regarding his diabetes eye screening which was stable.

14.11 September 2021

14.11.1 **Police.** On the 2nd the police receive David's shotgun license renewal and make the appropriate referral to the **GP** on the 7th.

14.11.2 **GP.** On the 21st David sees his GP re high blood pressure.

14.12 October 2021

14.12.1 **GP.** On the 5th David sees the nurse for a diabetes review and general health check.

14.12.2 **GP.** On the 26th both Jane and David receive their flu jabs.

14.13 November 2021

14.13.1 **GP.** On the 30th David is seen for a steroid injection to his knee.

14.14 February 2022

14.14.1 **Police.** On the 18th the police renew David's shotgun license, and the **GP** surgery are subsequently informed for their coding/alert.

14.15 March 2022

14.15.1 **GP.** On the 23rd David is seen for a steroid injection to his knee.

14.16 May 2022

14.16.1 **GP.** On the 23rd Jane is seen by her GP David also attended with her. She had pain in left scapula area for the last 3 days. She said she had been pushing a heavy lawnmower. Pain worse

on lying on that side, no cough, poor appetite. On examination there was no obvious rash, mild tenderness on palpation end of scapula, full movement of shoulder and chest clear.

14.16.2 **GP.** On the 25th Jane is seen by her GP she said she twisted her right knee before the weekend. It is now settling, minimal pain, examination showed minor pain and good movements.

14.17 June 2022

14.17.1 **GP.** Jane has a blood test taken by a health care assistant. During the appointment she mentioned infrequent migraines and a bad back. BP is 136/81. Advised to phone to discuss with GP.

14.17.2 **HOSP.** Jane is taken by ambulance with back pain and chest pain to hospital. She had suffered a heart attack and was fitted with a stent in hospital.

14.17.3 **HOSP.** 3 days later Jane is discharged from hospital.

14.17.4 **GP.** The day after her discharge Jane had a telephone encounter with her GP. Also, on that day David attends the surgery to collect a sample pot from the GP as Jane has developed diarrhoea.

14.17.5 **SWAST & Police.** The following morning David calls police and reports his wife had died of a suspected heart attack and asked for police attendance. Emergency services attended and both Jane and David are declared dead at the scene.

15. Overviews

This section summarises what information about Jane and David was known to each agency, and what professionals were involved with the family within the review period. Any other relevant facts or information are also included in this section.

15.1 Dorset Police

15.1.1 Dorset Police has reviewed all contacts with Jane and David. Research has been conducted of all police systems including NICHE, (crime database) STORM (police command and control system), Police National Computer and Police National Database. Both Jane and David were not known to the police. If information was known about them, it would appear in either these local or national systems. The only contact Dorset Police had related to the management of the shotgun application and renewals associated with David and the tragic events of June 2022.

15.2 NHS Dorset integrated care board (on behalf of the GP)

15.2.1 The Safeguarding Team at NHS Dorset has reviewed all contacts with Jane and David. Research has been conducted of GP electronic records with full access given to the author. Interviews were conducted with the Practice Manager and the GP during the process.

15.2.2 The primary care services for both Jane and David were within the same practice. They presented with usual chronic conditions and there was no evidence of any appointments that could relate to possible domestic abuse or emotional difficulties. Jane had a myocardial infarction in June 2022 requiring stent operation and according to records more intervention was required.

15.3 Dorset County HOSPITAL NHS foundation trust

15.3. The trust has reviewed all of its records relating to any interaction with Jane or David. The only interaction relates to Jane's in patient admission in June 2022 in relation to her heart operation.

16. Analysis

16.1 Hindsight Bias

16.1.1 As the report author the chair has attempted to view this case, and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome bias's' and evaluating the quality of a decision when its outcome is already known. However, the author has made every effort to avoid such an approach wherever possible.

Agency Involvement

16.2 Police

16.2.1 The only involvement of the police relates to David as a shotgun licence holder and Dorset Police have applications for shotgun certificates dating back to 2006. David kept his shotgun in a gun cabinet bolted to a solid wall in the upstairs office at his address. The 2006 application details that he had been shooting all his life and he had been asked to assist on two estates, and that he was almost a part-time gamekeeper.

16.2.2 The most recent application was completed by him on the 2nd of September 2021, and it was for one shotgun which was kept at his address within the cabinet. The referee he listed was a gamekeeper. The Medical Information Proforma was completed by his surgery Dr, and they had no information that they thought relevant to the application. A risk matrix was used, and the risk level assessed as low. This was further reviewed by the Firearms Licensing Inspector, and they confirmed the decision to renew the licence and the application was approved by Dorset Police on the 18th of February 2022.

16.2.3 Dorset Police have a firearms licensing policy. To ensure consistency the Firearms and Explosives Licensing Manager is responsible for developing local working practices in

accordance with the Authorised Professional Practice for Firearms Licensing[7] and the Home Office Statutory Guidance to Chief Officers 2021[8], Home Office Guidance on Firearms Licensing Law.

16.3 NHS Dorset Integrated Care Board (on behalf of the GP)

16.3.1 The GP services for both Jane and David were within the same practice. They presented with usual chronic conditions for a couple of their stage in life. Jane had a myocardial infarction (heart issue) in June 2022 requiring stent operation and according to records more intervention was required.

16.3.2 During their appointments it was noted that they would attend separately and at times together. Annual checks where completed, and it is noted that there appeared to be no barriers for either of them to present and have various conditions managed by the surgery.

16.3.3 The GP received the letter from police regarding application for a shotgun certificate and there is evidence that the GP reviewed the records, and no concerns were identified. Once the licence was granted the GP practice followed protocol and added the correct flag and patient alert to the records. Guidance for firearms licensing GP's is now available from the British Medical Association (BMA)[9]. This guidance takes into account the published Home Office Statutory Guidance for chief officers of police which came into effect in Nov 2021 (therefore this guidance was released after David applied to renew his licence).

16.3.4 From 1 April 2016, information sharing processes between GPs and police was introduced to ensure that people licensed to possess firearm and shotgun certificates are medically fit. In July 2019 the Home Office, the police and the British Medical Association agreed a Memorandum of Understanding which sets out the roles and responsibilities of police and doctors regarding the medical assessment of firearms applicants and the ongoing monitoring of those in possession of a firearms. These agreements are clear that the responsibility for deciding whether to grant or renew a firearm or shotgun certificate is entirely a matter for the Chief Officer of Police. In carrying out this function it is appropriate for the police to consider wider evidence relating to suitability, including medical evidence. Information provided by the applicant's GP or other suitably qualified doctor will help to inform the police decision, but it does not alter that the decision whether to grant is made solely by the police.

16.3.5 In this case the GP received the correct template available at the time and acted appropriately by reviewing the records, stating no concerns and adding a code, however at that time it was

[7] Firearms licensing | College of Policing

[8] Statutory guidance for police on firearms licensing - GOV.UK (www.gov.uk)

[9] Guidance for GPs on the firearms licensing process (bma.org.uk)

not required for GPs to complete a form unless there were concerns. NHS Dorset guidance has changed and there is a template that needs to be completed with the relevant medical information. Current guidance produced by Wessex LMC to support the GP/Doctors responsibilities on firearms licensing is referenced.[10]

16.3.6 There was appropriate management of correspondence about firearm application and prompt coding once this was granted. There is nothing noted in the medical presentation of either Jane or David that had any indicators of domestic abuse.

16.3.7 Paragon PARAGON - Domestic abuse - sexual abuse - stalking - counselling (paragonteam.org.uk) is the provider for DA services and are well known by the practice. However, the practice does not have leaflets in the waiting room, and the panel felt this would be beneficial. As a result, Paragon is sending new resources to all Dorset practices.

16.4 Dorset County HOSPITAL NHS foundation trust

16.4.1 Jane attended hospital via ambulance in June 2022 after experiencing central chest pain. She was directed straight to cardiac catheter laboratory due to confirmed inferior myocardial infarction (heart issue) that required cardiac catheter and cardiac stent insertion.

16.4.2 Jane was considered to have recovered well and was deemed medically fit 3 days later. She had the required review through echocardiogram post procedure and would require further treatment in 6 weeks' time for further percutaneous coronary intervention[11] (stent procedure). Jane was referred to the heart failure nursing team as she was found to have severe left ventricular dysfunction.

16.4.3 She was discharged with new medication as per inferior myocardial infarction primary medication provision. The ongoing treatment plan was for a consultant heart failure clinic in 4 months for complex device therapy and Jane required a repeat echocardiogram in 6 weeks' time.

16.4.4 Jane's stay in hospital was uneventful and she recovered well. She was mobilising, mentally orientated, and no concerns were voiced to staff. Safety netting[12] was completed regarding rehabilitation, post stent insertion, leaflets were given, and advice not to have no alcohol for 6 weeks. Information shared by Jane to staff about her personal circumstances, indicated that she lived with husband, she had no care or support needs & was fully independent.

16.4.5 Ward staff identified that David could collect her from the hospital for discharge home. David attended to collect Jane and when they were leaving, they tried to give the staff £40 cash for

[10] Wessex LMCs: Firearms - requests from police for medical information in relation to Firearms Certification.

[11] Percutaneous coronary intervention - Wikipedia

[12] Safety-netting in the consultation | The BMJ

the care Jane had received, staff tried to explain that they could not accept it. Both Jane and David stated the care was excellent. David threw the money to the nurse's station and said, "pretend you found it". Staff safely stored the cash to discuss with the ward leader the next day. Jane left her mobile charger at the hospital; she was contacted later that evening and she asked if the staff could please post it to her home address.

16.4.6 No concerns were voiced in respect of DA or issues with returning home to cardiac care staff whilst she was under the care of Dorset County Hospital NHS Foundation Trust. Simple discharge planning was utilised as she did not require on going care and support. Support would be through outpatients/ heart failure team. She was fully independent prior to discharge.

16.4.7 Dorset County Hospital NHS Foundation Trust has domestic abuse policies and procedures, training is embedded with mandatory safeguarding training for both adults and Children and Young Persons CYP, enhanced training has been undertaken by Dorset County Hospital NHS Foundation Trust staff delivered by Paragon Health DV advocate. Dorset County Hospital have had a DV health advocate for the past 2 years working with staff and people using their services. During the stay nothing was identified that would prompt any DA questioning or to raise any concerns.

Key Lines of Enquiry

16.5 1. Were there any concerns or reports made by family, friends, or neighbours about the vulnerability of the victim to abuse. Were opportunities missed to explore these?

16.5.1 There were not any concerns reported by family friends or neighbours regarding anything that would indicate anything other than a happy marriage. There was no indication from anyone spoken to by this review or the coronial process that indicated any form of DA.

16.6 2. Were there any barriers to services experienced by the victim or her family and friends, in reporting concerns, specifically any relating to abuse? How could these have been reduced?

16.6.1 There is no evidence that there were any barriers to services for both Jane and David. They both accessed their doctor's surgery for conditions that would be entirely normal given their stage in life. In fact, there is good evidence of support from the GP Surgery. The continued care for David's knee problems and annual health checks where undertaken and are examples of excellent care. Whilst the CSP cover a large rural area, in this case the GP surgery was only just under 3 miles from their house, a 10-minute drive. They both had access to a vehicle (they were a 2-car family) and were able to get themselves, whether together or individually, to the surgery. It's also important to note that whilst Jane and David lived the later years of their lives in Dorset, they spent the earlier parts of their marriage together in a similar rural area and in the words of the family "their life was countryside". Its therefore of note that the family believe they were able to navigate the lifestyle of rural Dorset.

16.7 3. Did Covid-19 impact on the ability of the hospital to satisfactorily engage with, understand and respond to the victim when assessing her vulnerability and any potential abuse. Could more have been done with the information available?

16.7.1 There is nothing in this review or panel discussions that has indicated COVID 19 had an impact on Jane's final hospital stay and the ability of the hospital staff to assess her vulnerability. Whilst of course it must be accepted that COVID-19 has had an impact across access to services for a great number of people and in particular those who are vulnerable there is no evidence that has been presented to this review that would indicate it was a factor in this case. Whilst it is noted that the 2 friends in this review had concerns on whether Jane should have been discharged there has been no evidence seen by the panel that suggest this was the case. At the time of her discharge Jane did not have any ongoing care and support needs identified, under the Care and Support Regulations 2014[13].

16.8 4. Did Covid-19 impact on the ability of the GP to satisfactorily engage with, understand and respond to the victim specifically in respect to the potential for identifying vulnerability and abuse. Could more have been done with the information available?

16.8.1 There is much commentary about the effects of COVID-19 and GP services. The panel are of the view that it has to be accepted that COVID-19 must have had a disproportionate impact on the vulnerable when GP services were remote. However, in this case there is no evidence that this was a factor.

16.9 5. The firearms license and process around assessing vulnerability and that of wider family.

16.9.1 There is clear evidence that the shotgun renewal was lawful and followed the appropriate legislation. The Police and the GP as stated previously in this report followed all the appropriate guidance. Whilst it is noted from friends and Peter that they thought David had given up shooting, for a shotgun renewal, unlike a firearms licence, the usage does not have to be established. However, one friend who raised the concern did state that he "shoots now and again". It would be perfectly normal to be able to partake less as illness occurs. The review is clear the shotgun was lawfully held and the whole process including vulnerability was dealt with correctly.

16.10 Domestic Abuse

Pattern of Abuse

16.10.1 Considering the government definition of domestic violence and abuse, which describes a pattern of incidents of controlling, coercive or threatening behaviour, the Review Panel was

[13] The Care and Support (Eligibility Criteria) Regulations 2014 (legislation.gov.uk)

able to determine there was no evidence of a history of domestic abuse. This conclusion is based on all the information provided to this review.

Predictability versus Preventability

16.10.2 The review panel considered how likely it was that Jane's death could have been predicted and therefore what opportunities there were to prevent it from happening. The panel concluded that there was no information that could have predicted the death of Jane.

Rural communities

16.10.3 The panel whilst agreeing there is no evidence of any DA in this review are all alert to and conscious of the under reporting within rural communities. The national rural crime network reports[14] that there are hidden victims, isolated, unsupported, and unprotected. Victims are being failed by services, systems and those around them. In response to this the CSP are committed to their rural community.

16.10.4 Dorset is largely a rural area. In 2021 Dorset Police reorganised in line with local authority areas meaning that within the Dorset Local Policing Area (LPA) there is a policing area policing rural crime, including domestic abuse. Dorset Police is currently undergoing a review of its operating model following an independent review with an aim to improve performance of Grade 3 response times for calls. These are call for service which do not require an immediate response but do require a police officer's attendance (such as some domestic abuse incidents). This will impact the rural area where travel times can be significant, and victims can be isolated.

16.10.5 Following uplift Dorset Police has now reopened Wareham patrol police station to improve response times and patrol coverage and reduce travel times to incidents. The force has also reopened a number of front counters to enable connectivity. Dorset Police has implemented community contact points for areas where there is no police station footprint. These dates are advertised on Facebook and members of the public can report crime at this site. In the near future the force has plans to invest further in an engagement vehicle to support connectivity. The LPA has targeted rural engagement for all crime including 40 engagement opportunities across the area over the summer of 2023. Neighbourhood engagement officers ensure that messaging including domestic abuse messaging is passed to its 115k followers.

16.10.6 Dorset Police undertook a programme of DA Matters training delivered by safelives. This was for all front-line officers in line with college of policing best practice and is considering a renewal of this training in the future. Dorset Police undertakes yearly vulnerability training for

[14] Captive & Controlled - Domestic Abuse in Rural Areas - National Rural Crime Network

all front-line staff. All front-line constables receive training in domestic abuse upon recruitment as part of initial training to ensure staff are able to recognise signs of abuse.

16.10.7 There is a good and varied offer across Dorset, supporting people affected by domestic abuse. This includes services for anyone affected by domestic abuse, including those who live in rural areas. More information on the services can be found at www.dorsetcouncil.gov.uk/dvahelp.

16.10.8 In addition, referenced at 16.3.7, PARAGON (specialist domestic abuse provider) delivers the Dragonfly Project. The Dragonfly Project develops community-based support for people affected by domestic abuse. Dragonfly champions are trained to provide a listening ear and a link to domestic abuse support agencies so that isolated people can access help. PARAGON developed the Dragonfly Project with people in the communities in mind. Those not supported by mainstream services can be signposted to help if they are affected by domestic abuse.

16.10.9 For many years the CSP has been working hard to tackle issues related to domestic abuse. The CSP believes domestic abuse, in all forms, is completely unacceptable and not to be tolerated. It is committed to tackling it by preventing abuse from happening, supporting victims, and prosecuting offenders.

1. prevention: we want to stop domestic abuse from happening altogether. To do that we will focus on actions and initiatives that are preventative so that fewer people become victims.
2. victims: victims of domestic abuse, whoever they are, will have access to services that keep them safe and prevent further harm.
3. offenders: offenders will be held to account for their actions.

16.10.10 Dorset Council, in consultation with the Dorset CSP published its Dorset Domestic Abuse Strategy 2021-2024. Dorset Domestic Abuse Strategy - Dorset Council The Strategy sets out how partners will work together to tackle domestic abuse. Ultimately it is an opportunity to ensure partners are putting in place a system that not only prevents abuse from happening in the first place, but also ensures that anyone affected by domestic abuse, has access to support, regardless of where they are on their journey. Since the Strategy was published the CSP has undertaken further research to help build partners understanding of domestic abuse. This has included work to understand the levels and impact of domestic abuse in rural communities.

16.10.11 Commissioning partners have also recently come together and agreed an approach to the co-design of future service provision and explore opportunities to align commissioning activity for services post March 2025. The aim of this work is to improve the journey of people experiencing domestic abuse, from initial referral through to recovery, creating a seamless pathway across all risk levels. This is to ensure continuity of care, maximise accessibility, and to enable a consistent service is offered across Dorset. This approach creates an exciting opportunity for partners and is focused on providing the best possible service to all people experiencing domestic abuse. Integral to this work will be to ensure the local offer meets the community needs including those who live in rural areas.

16.10.12 In addition, local partners continue to link in with central government departments to help shape national policy. And have good links directly into the Domestic Abuse Commissioner's office. Partners across Dorset continue to raise awareness of domestic abuse in a variety of ways, with the aim of raising awareness amongst those communities who may find it harder to access services (including those living in rural areas). Examples of this work includes displaying awareness material in GP surgeries, community areas, supermarkets, on council vehicles, as well as through the work of the Dragonfly Project, radio messages and social media.

16.10.13 The panel recognises all of the excellent work that has been undertaken or is in the pipeline. However, the panel are not complaisant, and are recommending that all agencies are to commit to a review of DA polices and training, to ensure those in the rural community understand more about DA, how to report, and the professionals know how to identify DA and signpost clients accordingly.

Learning Consideration – All agencies to review DA policies and training to ensure that their rural communities understand more about DA and how to report, and that professionals know how to identify and signpost those in rural communities.

17. Conclusion

17.1 Janes and David's deaths were tragedies and has affected their families and friends deeply. The evidence in this case is that Jane and David where very able people, who were reported to have loved each other dearly. They both had a car and whilst doing things together also did their own separate things.

17.2 Jane was an intelligent woman who had her own career prior to retirement. She had her own social network and as demonstrated in the night before her death she was very able to utilise social media. The reality is no one really knows why the tragic events unfolded in June 2022 and both deaths are an absolute tragedy for all involved.

17.3 The chair has researched the Home Office new DHR Library. Having researched potential published reviews that are similar in nature, over 65, female deceased, male dies by suicide, a shotgun was used, only 3 cases where identified. What was noted in those 3 reviews was that health also appeared as a factor. However, in those 3 reviews the deterioration of health appeared to be at a more advanced stage than was the case in this review.

17.4 In approaching learning and recommendations, the Review Panel has sought to do two things. First, to try and understand what happened and consider the issues in Jane's life that might help explain the circumstances of the death. Second, to use this case to consider a wider range of issues locally and nationally, including provision for victims of domestic violence and abuse.

Lessons To Be Learnt

17.5 Whilst the review did not identify any evidence of a history of DA within Jane and David's relationship the panel where open to any learning that could be identified. As a result, the panel have recommended that there is an opportunity to review policies and training around the specific needs of a rural community identified in 16.10.3.

Learning Consideration – All agencies to review DA policies and training to ensure that their rural communities understand more about DA and how to report, and that professionals know how to identify and signpost those in rural communities.

17.6 The review has shown us that there can be a sudden change in dynamic within a relationship. In this case with older persons due to health deteriorating, potential carer responsibilities, and the possible fear of losing your life partner, all could have been factors, however sadly the review will never know the full facts.

17.7 The review also identified whilst not a factor in this case the process of shotgun and firearm licensing does not take into account partners health conditions. It is recommended that nationally this is considered as an action and when GP checks are carried out partners health conditions are considered.

National Learning Consideration – Shotgun and firearms licensing GP checks should also consider partners health conditions.

17.8 The were no themes identified.

18. Recommendations

All agencies

Recommendation (R1) All agencies to review DA policies and training to ensure that their rural communities understand more about DA and how to report, and that professionals know how to identify and signpost those in rural communities.

National

National Recommendation (NR1) – Shotgun and firearms licensing GP checks should also consider partners health conditions.

Appendix 1

TERMS OF REFERENCE FOR DHR D18 REVIEW PANEL

1. Introduction

This Domestic Homicide Review is commissioned by the Dorset Community Safety Partnership in response to the death of Jane in June 2022.

This Domestic Homicide Review (DHR) was commissioned because it meets the definition detailed in paragraph 12 of the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2016). The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.

……Simon Steel……. has been appointed as Chair of the review panel. At the Review Panel meeting held on 20/04/2023 Peter Stride was selected however it has been agreed that Simon who is an associate of Peter will chair and author this review.

2. Purpose of the review

The purpose of the review is to:

- Establish the facts that led to the incident in June 2022 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The review will:

- Consider the period of 2 years prior to the deaths, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.
- Take account of the coroners' inquest in terms of timing and contact with the family.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Aim to produce the report within six months after the IMRs are requested subject to any criminal proceedings, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.

In addition, the following areas will be addressed in the Individual Management

Reviews and the Overview Report:

- Were there any concerns or reports made by family, friends, or neighbours about the vulnerability of the victim to abuse. Were opportunities missed to explore these?
- Were there any barriers to services experienced by the victim or her family and friends, in reporting concerns, specifically any relating to abuse? How could these have been reduced?
- Did Covid-19 impact on the ability of the hospital to satisfactorily engage with, understand and respond to the victim when assessing her vulnerability and any potential abuse. Could more have been done with the information available?
- Did Covid-19 impact on the ability of the GP to satisfactorily engage with, understand and respond to the victim specifically in respect to the potential for identifying vulnerability and abuse. Could more have been done with the information available?
- The firearms license and process around assessing vulnerability and that of wider family.

4. Family involvement

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

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

We will identify the timescale and process of the coroner's inquest and ensure that the family are able to respond to this review and the inquest avoiding duplication of effort and without undue pressure.

5. Legal advice and costs

Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. Each statutory agency may seek their own legal advice at their own discretion and cost.

6. Panel members, expert witnesses, and advisors

The following agencies and individuals are suggested to participate in the review

panel:

- *Dorset Police*
- *NHS Dorset*
- *Dorset HealthCare*
- *Dorset Council Adult Services*
- *Dorset Domestic Abuse Integrated Service Provider (The YOU Trust)*

As a minimum the following agencies will be asked to provide Individual Management Reviews to inform the report:

- *Dorset Police*
- *NHS Dorset*
- *Dorset HealthCare*

Other appropriate agencies and people may be identified through the course of

the review.

7. Media and communication

The management of all media and communication matters will be through a joint team drawn from the statutory partners involved. There will be no presumption to inform the public via the media that a review is being held in order to protect the family from any unwanted media attention.

Once confirmed by the Home Office, the full final report, along with the executive summary of the review will be published on the CSP website, with an appropriate press statement available to respond to any enquiries.

The recommendations of the review will be distributed through the CSP website and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

8. Data Protection Act 2018 and General Data Protection Regulations

A Personal Information Sharing Agreement has been produced to facilitate the exchange of personal information to meet the aims of a DHR and the requirements of data protection legislation.

Appendix 2

Glossary of Terms

Advocacy After Fatal Domestic Abuse	AAFDA
Community Safety Partnership	CSP
Domestic Homicide Review	DHR
General Practitioner	GP
Individual Management Reviews	IMR
Integrated Care Board	ICB
South West Ambulance Service	SWAS

Appendix 3

When and by whom	Who to	Method

21/06/23 Chair	Peter	Email introduction
30/06/23 Peter	Chair	Telephone
03/07/23 Chair	Peter	Email follow up
03/07/23 AAFDA	Chair	Briefing on referral
06/07/23 Chair	Jane's Sister	Email introduction
13/07/23 Chair	Peter	Email follow up
24/07/23 Chair	AAFDA	In person arranged Peter
25/07/23 Jane's sister Via CSP	CSP/Chair	Email wishing no further contact
01/08/23 Chair	Visit Peter	In person
02/08/03 Chair	Peter	Panel update
21/11/23 Chair	Visit Peter	in person with AAFDA with draft as requested
30/11/23 AAFDA	Chair	Email Family content with draft