Domestic Homicide Review

Dorothy/April 2018

Executive Summary

Author: Alan Critchley MA/CQSW

Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review Completed: 16th October 2019

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1. The Review Process

1.1 This summary outlines the process undertaken by the Domestic Homicide Review (DHR) panel in reviewing the homicide of Dorothy Walton, a 'Kent and Medway' resident.

1.2 The following pseudonyms have been used in this review for the deceased and her husband to protect their identities and those of their family members:

Deceased:	Dorothy Walton
Husband:	Derek Walton

1.3 Dorothy was a white British woman, in her mid 80s at the time of her death. Derek was a white British man in his late 80s.

1.4 Since Derek took his life immediately after taking Dorothy's, no criminal proceedings could be brought.

1.5 Dorothy and Derek had been married for 66 years and the sole evidence of abuse known was the final act. On this basis the family did not feel that a Domestic Homicide Review was appropriate and declined to participate in the review process. The panel agreed to undertake a review proportionate to the circumstances.

1.6 The panel acknowledge the traumatic effect that this has had upon remaining relatives and offer their sincere condolences to them.

1.7 The DHR Core Panel met on 10th May 2018 and agreed that the criteria for a DHR were met. The Chair of the Kent Community Safety Partnership then made the formal decision that a DHR would be conducted. All agencies that potentially had contact with Dorothy and/or Derek prior to the homicide were contacted and asked to confirm whether they had contact with the couple.

1.8 Those agencies that confirmed contact were asked to secure their files.

2. Contributing Organisations

2.1 Each of the following organisations were subject of an IMR or short report:

- Care Home A
- Town A - Local Authority
- Town A - Local Authority NHS Foundation Trust
- Kent Police
- Town A – Clinical Commissioning Group (Primary Care)
- Respite Care Home - Brief Report only

3. Review Panel Members

3.1 The Review Panel comprised of an Independent Chair and senior representatives of organisations that had contact with Dorothy and/or Derek. It also included an independent representative from SATEDA (Support and Action To End Domestic Abuse) and a senior member of Kent County Council Community Safety Team.

3.2 The members of the panel were:

Alan Critchley	Independent Chair
D/S Susie Harper	Kent Police (early stages)
D/S Lee Whitehead	Kent Police (later stages)
Catherine Collins	Adult Strategic Safeguarding Manager, Kent County Council Adult Social Care and Health
Richard Hill	Strategic Safeguarding Adults Lead, Town A - Local Authority (early stages)
Bill Brittain	Head of Specialist Services (Adults) Town A Local Authority (later stages)
Michele Sault	Designated Nurse for Safeguarding Children and Families, Town A - Clinical Commissioning Group
Bridget Fordham	Head of Safeguarding, Town A - NHS Foundation Trust
Theresa Ward	Care Home Manager, Care Home A
Honey-Leigh Topley	Community Safety Officer, Kent County Council Community Safety
Liza Thompson	CEO, SATEDA

3.3 Panel members hold senior positions in their organisations and have not had contact or involvement with Dorothy or Derek. The panel met on three occasions during the DHR process.

4. Independent Chair and Author

4.1 The Independent Chair and author of this report is a safeguarding consultant. He is a qualified and registered Social Worker. He has held a number of safeguarding roles including that of chair of an Adult and Children Safeguarding Board. Aside from his work as an independent reviewer he has no connections with agencies in Kent and Medway and does not live in the area.

5. Terms of Reference

5.1 The Terms of Reference for this review are set out in Appendix A of the Executive Summary and Overview Report.

6. Summary Chronology

6.1 In 2008 Dorothy began to experience the first symptoms of dementia. The diagnosis was confirmed in 2009.

6.2 Until the condition worsened in 2016 Derek, with help from his family, provided care for Dorothy. From 2016 onwards, there was increasing agency involvement until it proved no longer possible for Derek, even with assistance from agencies and periods of respite care, to support Dorothy at home and she was admitted to Care Home A in October 2017.

6.3 Derek visited the home on an, almost, daily basis. In April 2018 he asked the manager whether he might take Dorothy home to spend some time in the couple's garden as the weather had improved after a long winter. This was agreed and a few days later Derek took Dorothy home in a taxi.

6.4 Later that day the couple's son found both Dorothy and Derek deceased.

6.5 Prior to this final act there was no suggestion that there had been any violence in the relationship or that the 66 years of marriage was anything other than loving and supportive.

7. Conclusion

7.1 From the outset there was no suggestion that Dorothy and Derek had anything other than a loving relationship. Nothing has emerged from this review to contradict this and it can be confirmed that prior to the tragic event, there is no suggestion of violence or abuse in their relationship. In this instance the sole episode of abuse appears to have been the final one.

7.2 However, as Dorothy's dementia advanced, the strain on Derek increased, albeit he had support from family and agencies. There may have been insufficient attention paid to Derek. It seems that he was content to have been the main carer until October 2017 but the difficulty he was in was probably underestimated.

7.3 The loss that one partner feels when separated from another, in this case after 66 years, may well have been underestimated in providing personal support for Derek.

7.4 Although the outcome was an unusual and tragic one there are many people who find themselves in Derek's situation and this needs to be borne in mind when undertaking assessments and by those who design such assessments.

8. Lessons to be Learnt

8.1 This DHR does not identify any lessons that relate specifically to domestic abuse but does draw out some potential learning in relation to elderly people and separation.

8.2 After living together for 66 years with Dorothy, there would inevitably be anxiety for Derek once Dorothy moved to full-time residential care. This is to be expected and ongoing support for the carer should be considered in the assessment process.

8.3 The IMRs do not give a sense of how Derek was coping on a personal and emotional level, this may be because no one working with Derek knew. There was mention that Derek was not coping on a practical level, but this was insufficient to fully understand the situation that he was in. It may be helpful to make more explicit in assessments how the partner remaining at home will manage and how they can be supported in their change of circumstance.

8.4 There were some occasions where another family member contacted agencies shortly after Derek had done. Either Derek was not being heard when expressing his difficulty in looking after Dorothy or he was being stoical and downplaying the difficulty that he was in. Without talking to the family this cannot be further explored. Either way, those undertaking assessments need to be mindful of the difficulty for carers and that they may not be giving the full picture. This emphasises the importance of engaging with the wider family as necessary.

9. Recommendations

9.1 That agencies ensure that they can provide appropriate support for carers in the lead-up to their loved ones moving to residential care and that support continues to be available to the person who provided care once a person has been placed in residential care.

9.2 That GPs refer to the Dementia NICE pathways so that they follow good practice to do carers assessments. Carers should be invited to health reviews yearly and to also review how this is affecting their physical and mental health.

Appendix A

Kent & Medway Domestic Homicide Review

Victim – Dorothy Walton

Terms of Reference

1. Background

1.1 In April 2018, police officers attended Town A. They found that the victim had died by strangulation.

1.2 Derek Walton, husband of Dorothy Walton was also found deceased at the property having apparently taken his own life by hanging.

1.3 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 10th May 2018. It confirmed that the criteria for a DHR have been met.

1.4 That agreement has been ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office has been informed. In accordance with established procedure this review will be referred to DHR.

2. The Purpose of a DHR

2.1 The purpose of this review is to:

i. establish what lessons are to be learned from the domestic homicide of Dorothy Walton regarding the way in which local professionals and organisations work individually and together to safeguard victims;

ii. identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

iii. apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate;

iv. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

v. contribute to a better understanding of the nature of domestic violence and abuse; and

vi. highlight good practice.

3. The Focus of the DHR

3.1 This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Dorothy Walton.

3.2 If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

3.3 If domestic abuse was identified, this review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

4. DHR Methodology

4.1 Independent Management Reviews (IMRs) must be submitted using the templates current at the time of completion.

4.2 This review will be based on IMRs provided by the agencies that were notified of or had contact with Dorothy Walton in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Dorothy Walton or the perpetrator, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

4.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR must include all information held about Dorothy Walton and Derek Walton from 1st November 2016 to the date of her death in April 2018. If any information relating to Dorothy Walton as the victim, or Derek Walton being a perpetrator, or vice versa, of domestic abuse before 1st March 2017 comes to light, that should also be included in the IMR.

4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Dorothy Walton and/or Derek Walton. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2010, X was cautioned for an offence of shoplifting).

4.6 Any issues relevant to equality, i.e age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation must be identified. If none are relevant, a statement to the effect that these have been considered must be included.

4.7 When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an Overview Report will then be drafted by the Chair of the panel. The draft Overview Report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

5. Specific Issues to be Addressed

5.1 Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

i. Were practitioners sensitive to the needs of Dorothy Walton and Derek Walton knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Dorothy Walton and/or Derek Walton (as applicable)? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies

professionally accepted as being effective? Was Dorothy Walton and/or Derek Walton subject to a MARAC or other multi-agency fora?

iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

ix. Was this information recorded and shared, where appropriate?

x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

xi. Were senior managers or other agencies and professionals involved at the appropriate points?

xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

xiii. Are there ways of working effectively that could be passed on to other organisations or individuals?

xiv. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Dorothy Walton

and promote their welfare, or the way it identified, assessed and managed the risks posed by Derek Walton? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

xvi. Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?

xvii. How accessible were the services to Dorothy Walton and Derek Walton (as applicable)?