Domestic Homicide Review (DHR)

Into the death of Helen

2021

Executive Summary

Author: Dr Liza Thompson

Commissioned by: Norfolk Community Safety Partnership

Review completed: March 2023

EXECUTIVE SUMMARY

1. The Review Process

1.1. This summary outlines the process undertaken by the Domestic Homicide Review panel in reviewing the death of Helen, who lived in Town A, Norfolk.

1.2. Helen was a white British woman in her mid-fifties, who had been living with Huntington's Disease.[1]

1.3. The Perpetrator was a white British male in his mid-fifties.

1.4. On 21st October 2021, Helen's nephew contacted Police with a concern for her safety. Helen had not been seen in person since September 2018, with communications since then only being via text message.

1.5. Two of Helen's family members had knocked at Helen's home the day before, and her partner, the Perpetrator had told them that Helen had left him eighteen months before and moved in with a friend. They felt this explanation was unlikely as due to Huntington's Disease, she would need a carer and the name of the friend that the Perpetrator gave them was unknown to her family.

1.6. Norfolk Constabulary investigated Helen as a missing person, and on 30th October the Perpetrator was arrested for murder.

1.7. Less than a week later Helen's body was located in a shallow grave on the property she had shared with the Perpetrator (Westbrook Place).[2] A post-mortem examination documented the presence of severe traumatic head injuries of a blunt force nature, which were consistent with Helen having been repeatedly struck with a heavy blunt object. Her body had been in situ for a number of years.

1.8. Whilst on remand, the Perpetrator was found dead in his cell, with severe blood loss due to a self-inflicted wound to his neck.

[1] A condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotions.

[2] Not the real name

1.9. The DHR Gold Panel met on 2nd December 2021, and agreed that the criteria for a DHR were met. The Chair of the Norfolk Community Safety Partnership then made the formal decision that an DHR would be conducted. Agencies that potentially had contact with Helen and/or the Perpetrator prior to Helen's death were contacted and asked to confirm whether they had contact with them.

1.10. Those agencies that confirmed contact with the Perpetrator and/or Helen were asked to secure their files.

2. Contributors to the Review

2.1. Each Independent Management Report (IMR) was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation, before being submitted to the DHR Panel. None of the IMR authors or the senior managers had any involvement with Helen during the period covered by the review.

2.2. Each of the following organisations contributed to the review.

Agency/ Contributor	Nature of Contribution
Cambridge University Hospitals NHS Foundation Trust	IMR – in reference to the Huntington's Clinic which Helen attended
Norfolk and Waveney Integrated Care Board[3]	IMR – in reference to Helen and the Perpetrator's GP Practices
Adult Social Care	IMR
Norfolk Constabulary	Summary report and detailed financial statement pertaining to Helen and the Perpetrator's bank accounts
Department for Work and Pensions	Summary report – utilising the IMR template

3. Review Panel Members

3.1. The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Helen and/or the Perpetrator.

[3] From July 2022 the Norfolk and Waveney Clinical Commissioning Group is known as NHS Norfolk and Waveney Integrated Care Board – this is due to the newly formed Norfolk and Waveney Integrated Care System obtaining legal status following the Health and Care Act 2022.

3.2. The members of the panel were:

Agency	Name	Job Title
	Dr Liza Thompson	Independent Chair
OPCCN	Amanda Murr	Head of Community Safety
OPCCN	Nicola Jepson	Community Safety Officer
Department of Work and Pensions	Lisa Barraclough	Advanced Customer Service Manager
Cambridge University Hospitals NHS Foundation Trust	Tracy Brown	Adult Safeguarding Lead
NIDAS	Kristal Oakley	Lead IDVA for NIDAS
Adult Social Care	Helen Thacker	Head of Service – safeguarding
Norfolk and Waveney Integrated Care Board	Gary Woodward	Adult Safeguarding Lead Nurse
Norfolk and Waveney Integrated Care Board	Dr Maria Karretti	Named GP for Safeguarding Adults
Norfolk and Waveney Integrated Care Board	Sara Shorten	Safeguarding Adult Nurse
Norfolk Safeguarding Adults Board	Walter Lloyd-Smith	NSAB Manager

3.3. The panel met on six occasions during the DHR – including a meeting with Helen's family.

4. Author of the Overview Report

4.1. The Independent Chair, who is also the Author of this Overview Report, is Dr Liza Thompson.

4.2. Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHRs, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs) which has also assisted with this review. She delivers domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system, and she currently convenes a domestic abuse and sexual violence module at Canterbury Christchurch University.

4.3. Dr Thompson has no connection with the Community Safety Partnership and agencies involved in this review, other than currently being commissioned to undertake Domestic Homicide Reviews.

5. Terms of reference for the review

5.1. The review Panel first met on 18th March 2022 to consider draft Terms of Reference, the scope of the DHR and those organisations whose involvement would be examined. The Terms of Reference were agreed subsequently by correspondence and form Appendix A of this report.

5.2. The Purpose of a DHR

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
b) 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.
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
d) 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.
e) contribute to a better understanding of the nature of domestic violence and abuse.
f) highlight good practice.

5.3. The Focus of this DHR

5.3.1. This review will establish whether any agencies had identified possible and/or actual domestic abuse – in all its different forms - that may have been relevant to the death of Helen.

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

5.3.3. If domestic abuse was identified, the review will examine the method used to identify risk and the action plans put in place to reduce that risk.

5.3.4. This review will also consider current legislation and good practice.

5.4 DHR Methodology

5.4.1. Following notification of a domestic homicide, all of the Norfolk County Community Safety Partnership (NCCSP) members were asked to conduct a search of agencies records for information held about Helen and/or the Perpetrator.

5.4.2. Initial information was shared by Norfolk Constabulary, Adult Social Care, GPs for both parties, Department of Work and Pensions (DWP), Cambridge

University Hospitals NHS Foundation Trust (CUH), Norfolk and Norwich Hospital Trust, East of England Ambulance Service and Norfolk Community Health and Care. All other agencies returned a nil response – indicating they had not engaged with Helen during the scoping period.

5.4.3. The detailed information on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Helen and/or the Perpetrator. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

5.4.4. The majority of the IMRs were written by a member of staff from the organisation to which it relates. The GP Practice IMRs were written by the Norfolk Integrated Care Board. Each IMR signed off by a Senior Manager of that organisation before being submitted to the DHR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Helen or the Perpetrator during the period covered by the review.

5.5. Specific Issues to be Addressed.

- Were practitioners sensitive to the needs of Helen and the Perpetrator. Were they knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
- What mechanisms were in place to follow up with Helen, following her total disengagement with health services after October 2018?
- How did the Covid-19 pandemic restrictions effect mechanisms to follow up with Helen when she seemingly disengaged with services.
- Identification, understanding and responses to any economic abuse perpetrated by the Perpetrator.
- Was Helen identified as a vulnerable person due to living with Huntington's Disease?
- What were the agency responses to concerns raised by Helen's family in August 2018?
- When, and in what way, were Helen's wishes and feelings ascertained and considered?
- How accessible were the services to Helen?
- Did the agencies comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

- 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?
- 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?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Helen, and promote their welfare, or the way it identified, assessed and managed the risks posed by the Perpetrator?
- Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

6. Summary Chronology

6.1 Helen trained as a General Nurse during the early 1980s. In 1988 she retrained as a Mental Health Nurse, a role which she stayed in until she was medically retired due to the symptoms of Huntington's Disease.

6.2 The Perpetrator was a trainee mental health nurse, and Helen was his mentor – they soon began a relationship and purchased their own home in 1990.

6.3 Around 1994 Helen tested positive for the faulty gene which would lead to Huntington's Disease. She was formally diagnosed in 2007.

6.4 The couple separated in 2011– Helen's family stated this was due to the Perpetrator continuous infidelity, which they said was well known throughout the Perpetrator and Helen's workplace. The house was sold, and each party took their share of the proceeds.

6.5 In November 2012, Helen took early retirement due to her deteriorating health. She lived with her niece for a period of time, and then purchased a bungalow.

6.6 Throughout 2013-2015 the Perpetrator continued to stay in touch with Helen – and in 2014 he attended a neurology appointment with her.

6.7 In March 2015, Helen was awarded Personal Independence Payment (PIP) [4] which was paid directly into her bank.

---

[4] PIP is paid to people who have long term health conditions, and have difficulty doing certain tasks or getting around Personal Independence Payment (PIP): What PIP is for - GOV.UK (www.gov.uk)

6.8 In July 2015, Helen contacted Norfolk County Council's Adult Social Care Department for a care assessment. She cited deterioration of Huntington's. Helen is noted as requesting a discussion about sheltered accommodation, following an assessment she was not deemed as having unmet needs under the Care Act.[5] Helen had also met with a local authority housing officer and had been advised that if she applied for sheltered housing, she would be considered low priority as she was not faced with homelessness.

6.9 In early 2016, Helen moved into Westbrook Place where the Perpetrator was living – this is a large, remote farmhouse, which he was renting. Helen's family suggested that she had stayed there for "a short break" and then did not return to her bungalow.

6.10 On 29th April 2016, a payment was made from Helen's account into the Perpetrator's entitled "rent" – at this point the Perpetrator's bank account balance stood at around £500. Payments continued from Helen's account into the Perpetrator's account continuously until the Perpetrator was arrested and subsequently took his own life.

6.11 Throughout 2016 and 2017 Helen attended routine vaccinations and neurology appointments.

6.12 On 15th July 2017, Helen attended Helen's great niece's 21st birthday BBQ at Helen's nieces house. She is described by her family as being in good spirits and enjoying herself. The Perpetrator had dropped her there, and did not go into the house, Helen's nephew and his partner dropped her home to Westbrook Place. They told the Chair that Helen showed them around the house and that the Perpetrator was frosty and unwelcoming. This was the last time that any of the family saw Helen.

6.13 On 29th August 2017 Helen's nephew called Adult Social Care on behalf of Helen. He stated that his aunt was neurologically impaired by Huntington's Disease and had phoned him asking for help to find an alternative place to live because she believed that the Perpetrator was using all her money, he made her pay for everything, and Helen's nephew was concerned that the Huntington's was making her more vulnerable to financial exploitation. Helen had told her nephew that she paid all the bills and the rent for Westbrook Place. Helen's nephew explained that Helen and the Perpetrator had split up following Helen's diagnosis but that 18 months ago they had got back together, and Helen had moved into the Perpetrator's property.

6.14 The Assistant Practitioner spoke with Helen's friend who was named as her next of kin. She stated she did not know of any concerns. The friend called Helen, who did not tell her of any concerns – it is not known if the friend also spoke to the Perpetrator or if he was in the room when she spoke to Helen.

[5] 2014

6.15 The following day, the Assistant Practitioner called Helen, who agreed to answer "yes and no" questions as the Perpetrator was present in the room. She did not want to raise any concerns, and said she was having a bad day when she called her nephew – following this call, the adult social care involvement ended.

6.16 From October 2017 to October 2018, Helen attended routine appointments, and met her friend Jill for lunch as usual.

6.17 On 5th December, Jill received a text from Helen's phone cancelling their lunch date that day.

6.18 From December 2018 onwards Helen did not attend any of her neurology appointments or respond to routine vaccine reminders. Repeat prescriptions were requested online for Helen until February 2019, when she was sent reminders about a medication review. These reminders were not responded to, and Helen was not issued any more prescriptions.

6.19 The family received text messages from Helen's phone on their birthdays, and sporadically across the years – they could tell that it was not Helen texting directly but assumed that the Huntington's condition had worsened, she could not use her hands to text, and she was dictating the text to the Perpetrator to type out.

6.20 On 21st October 2021, Helen's nephew contacted Norfolk Constabulary with concerns about Helen. Helen's niece and great niece had been to Westbrook Place the day before and had been told by the Perpetrator that Helen had moved away 18 months previously, to live with a friend, who the family had not heard of. Helen's nephew told police that the Perpetrator had been controlling in the past, with concerns about economic abuse, and Helen would need a carer wherever she was living due to Huntington's Disease.

6.21 Following Helen's niece and great niece visit to the house, the Perpetrator sent a text message from Helen's phone, purporting to be Helen, stating that she was ok and had just started new medication which meant she couldn't speak to them.

6.22 Police conducted background enquiries and could not find an alternative address for Helen. On 24th October 2021 police visited the Perpetrator at home. He told them that Helen had moved out in June. A formal missing person's report was created for Helen on 25th October 2021.

6.23 On 27th October a strategy meeting was held involving police and health professionals including Practice A and CUH. This meeting determined that it would be very difficult for Helen to be living in the country with Huntington's without any sign of her on medical records since her last known appointment in October 2018.

6.24 On 28th October 2021, a murder investigation commenced. On 30th October the Perpetrator was arrested on suspicion of Helen's murder, and on 1st November he provided a written statement admitting that he was responsible for Helen's death.

6.25 Over the next few days Police searched the grounds of Westbrook Place and located the remains of Helen's body.

6.26 The Perpetrator was found deceased in his prison cell on 29th December 2021.

7. Conclusions

7.1 It is clear from speaking to family and friends that although there were never any obvious signs of physical violence in the form of injuries and Helen did not formally disclose abuse to any professionals- she had been living with a coercively controlling man.

7.2 Although she had not reached out for help from professionals, Helen had discussed the Perpetrator's behaviour with Jill– who had reflected on these conversations, following her own raised awareness of domestic abuse, and believed his behaviour to be coercively controlling.

7.3 Helen had also disclosed issues of financial abuse to her nephew in August 2017, only a short time after spending the day with the family at her niece's birthday party. On this occasion, Helen's nephew and his partner had dropped Helen off to Westbrook Place, and this had been the last time that any of the family had seen Helen in person.

7.4 The Perpetrator's isolation of Helen was made easier by her Huntington's Disease, however he exacerbated this isolation by placing her in a home which was miles from anywhere, by making it awkward for her to visit friends and family, by making it awkward for them to visit her, and by dwindling away her savings and income on his lifestyle, which Helen's family described as extravagant.

7.5 Professor Evan Stark - one of the architects of the Coercive and Controlling Behaviour offence[6] - describes coercive control as being "invisible in plain sight".[7]

7.6 Stark introduces the concept of a "cage" in which the abused subject is caught. He warns that until the nature of the cage is identified, practitioners will not be able to aid the victim in escaping. He states: "[the] barrage of assaults, the locked door, missing money, rules for cleaning, text messages…[are] recognised as bars."[8] Abuse of this nature – the "cage" - is not visible to those outside of the private family domain.[9]

7.7 Marianne Hester describes coercive control as a "long thin offence." She explains that abusers often do not stand around with blood on their hands waiting to be arrested and victims do not always present to professionals with visible injuries.[10]

---

[6] S.76 Serious Crime Act 2015

[7] Stark E *Coercive Control: How Men entrap Women in Personal Life* (2007) p.13

[8] Stark, above n 15 p.198

[9] *Ibid* p.14

[10] Hester, M *Domestic Abuse Masterclass: Thames Valley Police* (October 2013) Cited in Monckton

Coercive behaviours can be subtle and tend to be particular to the individuals in the relationship. Stark defines this as an "individualised package of behaviours developed through a process of trial and error for the victim by the person who knows her most intimately."[11]

7.8 The point where Helen's gender and disability intersected, is the point where she was at her most vulnerable. Her relationship with the Perpetrator had started before Huntington's was diagnosed, and before she was symptomatic, yet at this point the Perpetrator was already described by those the Chair spoke to, as narcissistic. Once her symptoms began, her dependency on the Perpetrator, his isolation of her, and in turn her risk levels– all rose. Thiara, Hague and Mullender have argued that support services often do not recognise the intersectionality of domestic abuse and disability, and the resulting "complex nature of women's abuse experience" – with each service provision not being set up to respond at the intersection.[12] Helen was not asked about domestic abuse when she accessed health provision, she was not responded to adequately when her nephew reached out on her behalf to adult social care, she was never given information – nor accessed – domestic abuse services.

7.9 As introduced above, Helen's Huntington's Disease placed her in a dependent position, where she was reliant on the care of the Perpetrator. Research shows that women with disabilities are at particularly high risk of abuse, from violence but also from abuse that targets their disability.[13] In Helen's case, this is evidenced in the financial abuse she experienced, with the Perpetrator spending her savings on his lifestyle, which was potentially made easier for him by Helen's lack of ability around money management. This is a factor of Huntington's which her family described to the Chair, and which was recorded on the neurologist's notes for Helen as being an issue for her.

7.10 The Perpetrator moved Helen into his home, at the point where he was about to run out of money. Whether Helen saw this move as a reconciliation with the Perpetrator, or whether she viewed it as the supported accommodation she had indicated to the local authority that she needed; the timing of this move, and the subsequent bank transfers from her savings into his account was an act of financial abuse which was largely invisible and which continued after Helen's death.

7.11 Helen appeared to be aware of the financial abuse by August 2017, when she called her nephew for assistance. Helen's nephew contacted ASC to report his

---

Smith, J, Williams, A and Mullane, F *Domestic Abuse, Homicide and Gender: Strategies for Policy and Practice* (2014) p.17

[11] Stark, E above n 15 p.206

[12] Thiara, R, Hague, G and Mullender, A "Losing out on both counts: Disabled Women and Domestic Violence" *Disability and Society* 20 (6) (2011) and Hague, G, Thiara, R and Mullender, A "Disabled Women, Domestic Violence and Social Care: The Risk of Isolation, Vulnerability and Neglect" *The British Journal of Social Work* 41 (1) (2011)

[13] Plummer, SB and Findlay, PA "Women With Disabilities' Experiences with Physical and Sexual Abuse: Review of Literature and Implications for the Field" *Trauma, Violence and Abuse* (2012)

concerns about Helen, and as will be discussed below, this was a missed opportunity for the financial abuse to be made visible.

8. **Lessons to be Learnt**

8.1. Agencies involved in the review identified learning which has already been implemented, or started, since Helen's death. These will be shared in the following section. Also, through the process of the review, the panel identified three key themes of learning which have informed the DHR recommendations detailed in section 18 below.

8.2. Department of Work and Pensions

8.2.1. DWP continually review their domestic abuse and violence guidance and it is easily accessible to staff via a Department for Work and Pensions wide intranet site.

8.2.2. DWP has recruited Advanced Customer Support Senior Leaders (ACSSL) forming a Nationwide network of support that provides clear escalation routes for cases involving claimants deemed at risk of abuse, harm, and neglect.

8.2.3. Carers are provided with signposting when they make an application for carers allowance. The support available includes advice about financial support, assessments, available support services and carers' rights. This information is on the carers allowance entitlement letter they receive– and is also available on the gov.uk website.

8.2.4. This review has identified learning around the lack of recording of partners who are carers and claiming Carer's Allowance, by any agencies other than the DWP. The findings of this review could contribute to national learning, and will therefore be shared with the relevant DWP Directorates, and the Domestic Abuse Commissioner's Office DHR Repository.

8.3 Cambridge University Hospitals NHS Foundation Trust

8.3.1. The Huntington's Disease clinic have reported that they are more proactive with clinic appointments now than they were during the review period. Staff will contact patients ahead of their appointments to check if they are able to attend. Appointments are now centralised and are no longer sent via the clinic or secretarial staff, ensuring records are held electronically.

8.3.2. When reviewing the Did Not Attend Policy for this review, the IMR author became aware that it was difficult to locate. She identified the need for a standalone "Missed Appointments" policy, which would also include "was not brought" as some patients are unable to bring themselves to appointments – this is in line with the policy for children and young people.

8.3.3. CUH have also been implementing plans for the introduction of Routine Enquiry, for all patients attending the Emergency Department, Assessment Units and Outpatient Clinics.

8.4. Norfolk and Waveney Integrated Care Board

8.4.1. Practice A identified that the named GP should be informed if medication is left uncollected from the practice dispensary, particularly where that medication should not be stopped abruptly, and/or if the repeat medication should not be ceased with the authorisation of the named GP. Once informed, the named GP would be able to make a clinical decision about next steps, for example attempting to contact the patient or their next of kin.

8.4.2. The practice also identified the need to ensure robust communication between the surgery and specialists in particular with respect to communication of medical problems and medication as was requested by the specialist on two occasions in this DHR.

8.4.3. GP practices should have both domestic abuse and safeguarding adult policies and should be encouraged to have a domestic abuse champion within the practice team.

8.5. Adult Social Care

8.5.1. Safeguarding practice has evolved since Helen's nephew contacted ASC in 2017 with concerns about Helen. Since then, there is much greater accountability for decision making and recording of decision making. There is also a much greater awareness of domestic abuse. The Care Act 2014 increased the focus on domestic abuse, by including it as a specific category of abuse. Awareness has been further strengthened by the Domestic Abuse Act 2021.

8.5.2. Early Learning from this review has already been shared with ASC staff to highlight the importance of following up concerns raised by family members in a safe way, including speaking to possible victims of abuse away from the alleged abuser, and understanding financial abuse.

8.5.3. Communications have been shared with all staff regarding the need to record conversations verbatim, when speaking with people who have communication difficulties, particularly when discussing risk and harm. This is to ensure it is clear what they were asked, and what their specific response was.

8.5.4. In 2017, ASC became a member of the Domestic Abuse and Sexual Violence Group (DASVG), a subgroup of which focuses on the specific needs of adults with care and support needs who are experiencing, or who are at risk of, abuse or neglect.

8.5.5. Until recently, domestic abuse has been covered within ASC's general safeguarding procedure, however since 2019 a standalone domestic abuse procedure has been implemented. The domestic abuse procedure recognises the unique complexities of domestic abuse, particularly for adults with care and support needs who are at risk.

8.5.6. In 2021, ASC carried out a learning review which led to an updated and refreshed training programme for staff. The updated programme includes understanding and identifying coercion and control, financial abuse and professional curiosity. The training content increases in complexity at higher levels.

8.5.7. The higher-level course "learning lessons from Safeguarding Adults Reviews" has been renamed to "learning lessons from Safeguarding Adults Reviews and Domestic Homicide Reviews" and will have a heavier focus on domestic abuse. The Making Safeguarding Enquires course covers making a safe enquiry when domestic abuse is an issue. All courses will address how coercion and control may affect a person's capacity to make decisions about their safety and what to do if the person is at risk of harm. During 2022, ASC commissioned a specific standalone course for all staff on domestic abuse and coercion and control which is mandatory.

8.5.8. DASH training has been extended, from qualified practitioners only, to all frontline ASC staff. The training is delivered by Norfolk Police, with two sessions available each month.

8.5.9. Professional curiosity has been highlighted to all staff by internal communications, and through the Norfolk Safeguarding Adult Board.

8.5.10. A procedure has been developed which highlights the requirement for a manager to be consulted before a case with outstanding risk is considered for closure. There is also a clear process which requires the AP to report their findings to the SAPCs for further decision-making and next steps. This has made decision-making safer.

8.5.11. Exception reports have been developed which identify cases where safeguarding concerns were initially raised, and when further information was gathered there was no need for a S.42 enquiry to proceed. From these cases, a dip sample is taken, which are looked at to ascertain where the team managers agree with the decision not to proceed to S.42 enquiry. Any issues identified feed into ongoing training.

8.5.12. During the panel's meeting with Helen's family, a question was asked about the monitoring of communications, to ensure that procedures and practices described above are adhered to. The ASC panel member clarified with team managers after the meeting that calls into the CSC are recorded and recordings are retained for a period of six months; a sample of these calls are assessed by Quality Assurance Officers and Team Leaders.

8.5.13. During the interview with the IMR author, the AP commented that a great deal of information needs to be shared with ASC staff and that it is easy to miss important pieces of information. The AP therefore suggested the development of safeguarding "cribsheets" which cover questions that APs need to ask gather information in various situations, this would be updated once a year in line with changes to policy and practice.

8.5.14. The Connecting Communities programme in SCCE will remodel the front door service to address high pressure and high volume.

8.6. Routine Enquiry

8.6.1. As detailed above in 16.2 victims and survivors of domestic abuse want to be asked about the abuse. Practitioners, and especially those in health settings, are perfectly placed to ask about abuse as part of a routine enquiry. This does not rely on subjective "professional curiosity" and becomes embedded in standard practice.

8.6.2. As detailed within the analysis of Helen's involvement with CUH and Primary Care, there had been little or no follow up with Helen when she either failed to attend appointments, failed to book routine vaccines and screenings, pick up medication or order repeat prescriptions. The reason given for this was a lack of safeguarding concerns – no issues of risk of harm had been raised, and therefore her sudden lack of engagement was not followed up. Due to there being no known concerns for Helen's welfare, there was no policy requirement for a follow up, which will be discussed in 16.7. However, Helen had not been asked about abuse, or any other risks of harm.

8.6.3. It is problematic to rely upon a policy of only following up on disengagement when concerns have been raised, when the onus is placed upon the patient – who may have care and support needs – to disclose concerns unprompted.

8.6.4. Helen had told people about the Perpetrator's behaviours. If she was asked about this by professionals, she may not have disclosed the financial abuse and control which she had disclosed to her friend Jill and raised with her nephew. However, had she been asked every time she was seen by a medical professional it may have prompted her to either disclose at some point, or it may have planted a seed to seek help elsewhere.

8.6.5. In 2008 Public Health Scotland included routine enquiry in their Gender Based Violence Action Plan,[14] and reiterated this, as a workstream, in the 2017 Equally Safe Delivery Plan.[15] Routine enquiry involves asking all women at assessment about abuse, regardless of indicators of suspected abuse. It is in place for mental health, sexual health, health visiting, substance misuse and maternity services.

[14] CEL 41 (2008) - Gender-based violence action plan (scot.nhs.uk)
[15] Equally safe: delivery plan - gov.scot (www.gov.scot)

8.6.6. NHS Boards in Scotland provide ongoing routine enquiry training for new and existing staff, and their guidance requires all frontline staff to be trained in the approach before being put into practice. It is unrealistic to expect all frontline staff to be experts in responding to disclosures of abuse, however by implementing routine enquiry staff can;

- Provide a supportive environment to help disclosures.
- Gather information on the health problems associated with the abuse.
- Provide information, signposting, and referrals to specialist support where appropriate.
- Document disclosures of abuse in the patient's case file.

8.6.7. Helen's case highlights how the use of routine enquiry could have encouraged her to disclose the Perpetrator s behaviours, which may have led to a referral into specialist services who could advise Helen regarding the financial abuse. A disclosure of abuse could have also triggered a more proactive response to her sudden disengagement with health services.

8.6.8. Norfolk and Waveney's newly created Integrated Care Board are ideally placed to encourage providers to adopt and develop processes whereby routine enquiry becomes embedded in practice.

8.7. Proactive Follow Up

8.7.1. Prior to 12th December 2018, when she failed to attend her neurology appointment at CUH, Helen was consistent with her attendances at routine appointments, and procedures. Although, as confirmed by the Huntington's Disease Association, it is quite common for people with Huntington's Disease to fail to attend their appointments, or be sporadic with their engagement, non-attendance was out of character for Helen.

8.7.2. When Helen failed to attend the neurology appointment in December 2018, a voicemail was left for her, and a further appointment sent for March 2019. When she failed to attend this appointment, no further follow up was made. There is currently no mechanism in place at CUH for proactive follow up when a patient fails to attend.

8.7.3. When Helen failed to book a medication review with her GP in February 2019, there was no attempt made to follow this up with her. In July 2021, the Practice ran a computer search to identify patients who had not reordered their medication– Helen's name appeared on this search. As a result of this, a decision was made to stop further issue of her medication. No other action was taken.

8.7.4. Both CUH and Practice A were following their policies and procedures, which did not require a proactive follow up with Helen. As discussed above, there had been no concerns recorded on Helen's records with her GP or her neurologist, and she had not been flagged as vulnerable on her GP records.

8.7.5. Health care settings should be encouraged to develop policies which require a proactive response to sudden non-attendance, and/or sudden failure to order/collect mediation. Ideally this should be regardless of identified vulnerabilities or concerns raised – however realistically this may not be possible due to high caseloads, and therefore the required processes identified above, of routine enquiry and extension of vulnerability categories, are vital.

8.7.6. Another situation where health and social care services need to act proactively is following when concerns are raised by third parties. As has been discussed above, ASC processes have been developed, and training has been improved in light of the Care Act's inclusion of domestic abuse as a category of abuse in adult safeguarding. However, it remains imperative that all services learn lessons from this review, in terms of how to respond to concerns of domestic abuse being raised by a third party.

8.7.7. When concerns are raised by someone other than the potential victim, proactive communication in the form of information gathering is vital. This should begin with holding a safe conversation with the potential victim, away from the alleged perpetrator and where possible in person, especially if the victim has care and support needs.

8.7.8. Where a patient has suddenly disengaged from health and care services, and/or has failed to collect or order repeat prescriptions - professionals should attempt to gather information from known sources to build a picture of the potential victim's situation.

8.7.9. For example, in Helen's case, when it became apparent that she was no longer requesting her medication, the GP Practice could have contacted Helen's neurologist to determine whether she had been attending her appointments with CUH. Similarly, when Helen had failed to attend two appointments, and had not been contactable via telephone, CUH personnel could have contacted Helen's GP to determine whether she had recently been seen by her GP.

8.7.10. The learning from this review should be shared with all health and social care services in the form of an accessible case study tool. This would remind staff of the importance of proactivity in situations such as Helen's.

8.7.11. Health and social care services should be encouraged to develop their Did Not Attend policies to include the concept of "was not brought", and to include a proactive approach to assessing the welfare of patients who suddenly disengage, and/or fail to collect or order repeat medication.

8.7.12. The strategy meeting held after Helen's disappearance became apparent, enabled a coordinated discussion, and information sharing, which led to the Police launching a murder investigation. For Helen, this information sharing forum came far too late, however the impact of bringing agencies together to share what they each know should be acknowledged.

8.8. Financial Abuse Awareness

8.8.1. Financial abuse as a form of coercive and controlling behaviour is often invisible in plain sight.[16]

8.8.2. Financial abuse involves a perpetrator using/misusing money which limits and controls their partner's current/future actions, and freedom of choice. Manipulation of money is one of the most prominent forms of coercive control, depriving women of the material means for escape. With no access to independent income, they have little choice but to remain in the relationship despite the threats and risks of harm.[17]

8.8.3. As described above at 16.4, Norfolk have introduced a role within ASC with the specific remit of supporting adults with care and support needs, who are faced with financial issues. This is good practice, and the availability of this resource should be shared with frontline practitioners throughout health and social care.

8.8.4. Practitioners throughout health and social care services should be required to attend specialist financial abuse training, to assist with the identification of this form of coercive control, and to ensure an up-to-date knowledge of services available to those affected.

8.8.5. The availability of the Financial Abuse and Safeguarding Officer role should be shared with agencies and services. This will encourage and empower staff to ask questions about financial abuse.

8.8.6. The impact of the Financial Abuse and Safeguarding Officer role should be shared.

---

[16] Financial and economic abuse - Women's Aid (womensaid.org.uk)

[17] Sharp, N (2008) "What's Yours is Mine": the different forms of economic abuse and its impact on women and children experiencing domestic violence. London: Refuge

9. Recommendations

The Review Panel makes the following recommendations from this DHR:

	Recommendation	Scope	Action To Be Taken	Lead Agency/ Accountable Professional	Key Milestones	Target Completion Date	Outcome and Date of Completion
1.	Creation of a standalone Missed Appointments Policy/Process for adult patients, which includes guidance for specialist clinics for when a patient does not attend successive appointments.	CUH	The action will be taken to the Joint Safeguarding Committee Discussion with Named Nurse for children – to discuss merging the process with adults.	CUH adult safeguarding lead will take this action.	Committee member takes this action.	7th February 2023 December 2022	This was agreed that it will be a merged policy/process for adult/children.
2	The introduction of a pilot Routine enquiry process for all patients within the Emergency Department, Assessment Units, and Outpatient Clinics.	CUH	Deputy Chief Nurse agreement to proceed. The action will be taken to the Joint Safeguarding Committee to progress the plans. Independent Chair to provide a learning brief for the Committee.	CUH adult safeguarding lead CUH adult safeguarding lead Independent Chair	Joint Safeguarding Committee to take lead on the process.	December 2022 May 2022 April 2022	See recommendation 9 which links with this

3	An in-house process for communication regarding disengaging patients in primary care by notification to the Safeguarding Lead GP for the Practice, or the responsible GP for the patient.	GP practices within Norfolk and Waveney	Named GP for Safeguarding Adults to share anonymised case study with GP practices in Norfolk and Waveney to shared identified learning and recommendation for an in-house process to be adopted where the responsible GP is notified when a patient does not respond to repeated requests for medication review.	Norfolk and Waveney ICB/Named GP for Safeguarding Adults	Case to be written by Named GP for Safeguarding Adults/ICB Safeguarding Adult Team for inclusion in Safeguarding primary care monthly bulletin. This action to be shared at forthcoming Safeguarding leads meeting once DHR completed.	Circa. May 2024	
4	GP practices to be encouraged to adopt a policy for domestic abuse	GP Practices within Norfolk and Waveney	A template policy has been developed by the Safeguarding Adult team for Norfolk and Waveney ICB and has been shared widely.	Safeguarding Adult Lead Nurse and Named GP for Safeguarding Adults Norfolk and Waveney ICB	Template policy has been reviewed by NIDAS, the OPCCN and by the Norfolk Local Medical Committee; and has been promoted to primary care with support of communications team at Norfolk and Waveney ICB.	June 2022	
5	GP practices to be encouraged to adopt a template policy for Safeguarding Adults	GP Practices within Norfolk	A template policy has been developed by the Safeguarding Adult team for Norfolk and Waveney ICB and has been shared widely.	Named GP for Safeguarding Adults Norfolk and Waveney ICB	Template policy has been reviewed by safeguarding experts within the ICB, the Norfolk Local	June 2022	.

		and Waveney			Medical Committee; and has been promoted to primary care with support of communications team at Norfolk and Waveney ICB		
6	Primary Care to be made aware of the domestic abuse champion role and how to access training	GP Practices within Norfolk and Waveney	Overview of the domestic abuse champion role and signposting to domestic abuse champion training to be provided to all practices within Norfolk and Waveney	Safeguarding Adult team for Norfolk and Waveney ICB	Information to be included in the monthly joint safeguarding children and adult monthly primary care newsletter. Direct Email about the DA Champions initiative sent to all GP Practices Utilising Protected Learning Time to raise awareness of the DA Champions role	March 2023	
7	GP Practices to reflect on the learning from this review – to ensure they have a process in place when patients do not respond to requests to attend for a monitoring check, related to their medication.	GP Practices within Norfolk and Waveney	Named GP for Safeguarding Adults to share anonymised case study with GP practices in Norfolk and Waveney to shared identified learning and recommendation for an in-house process to be adopted where the responsible	Norfolk and Waveney ICB/Named GP for Safeguarding Adults.	Case to be written by Named GP for Safeguarding Adults/ICB Safeguarding Adult Team for inclusion in Safeguarding	Following publication	

			GP is notified when a patient does not respond to repeated requests for medication review.		primary care monthly bulletin. This action to be shared at forthcoming Safeguarding leads meeting once DHR completed.		
8	New patient registration forms to include a question about domestic abuse.	GP Practices within Norfolk and Waveney	Named GP for Safeguarding Adults will raise this at a safeguarding leads meeting	Norfolk and Waveney ICB/Named GP for Safeguarding Adults.	Safeguarding leads would take this in their own practices	April 2023	
9	Home Office and DA Commissioner Office to be made aware of the need for a national routine enquiry review and/or guidance for ICBs nationally.	NCCSP	This review to be flagged as a case study for the need for routine enquiry throughout health and social care settings.	Independent Chair and NCCSP lead	To assist with national guidance and learning around the need for routine enquiry	June 2023	
10	Impact report for the Financial Abuse and Safeguarding Officer role to be created and shared with the Domestic Abuse Commissioner's Domestic Homicide Review Repository to aid wider learning around financial abuse. A briefing paper regarding the Financial Abuse and	Norfolk County Council	Impact report to be sent to DHR repository upon publication of the report. Briefing paper created Briefing paper included within the Appendix for this report	Finance and Commercial Services Team	To assist with national guidance and learning around the impact of a Financial Abuse and Safeguarding Officer role, both on local authority finances and on the welfare of vulnerable people.	Following publication March 2023	

	Safeguarding Officer role to be made available within this overview report for reference.					Following publication	
11	An anonymised case study to be developed for use within training for all agencies, highlighting the need for routine enquiry and providing early learning ahead of publication of the report (see Appendix C).	Independent Chair	Case study to be developed. Case study to be distributed to Norfolk County Council providers. Case study to be available for use by all agencies.	Independent Chair	To highlight the need for routine enquiry but using the anonymised circumstances of this review to aid with training.	March 2023 March 2023 March 2023 within Norfolk Following publication nationally (available as an Appendix to the report).	
12	Once published, the learning from the review around family engagement with DHRs will be shared with the Home Office/National DHR Repository.	NCCSP/Independent Chair	Upon publication, the Independent Chair will prepare a reflective analysis of engaging the family within the process, and this will be shared with the Home Office and DA Commissioner DHR Repository.	NCCSP/Independent Chair	To contribute to learning around DHR processes	Following publication	

13	Once published, the learning from this review will be shared with the National DHR Repository, regarding the invisibility of intimate partner carers	NCCSP	Upon publication, the report will be shared with the DA Commissioner DHR Repository.	NCCSP	To contribute to national thematic learning	Following publication	
14	Once published, the learning from this review will be shared with the Retirement Services Directorate and the Customer Experience Directors, regarding the invisibility of carers and Carers Allowance.	NCCSP	Upon publication, the report will be shared with the DWP panel representative by NCCSP, to be shared with the Director of the Retirement Services Directorate and the Customer Experience Directorate.	NCCSP/ DWP	To contribute to DWP learning	Following publication	