Domestic Homicide Review

Overview Report

'Barbara'

Died June 2021

Chair: Ged McManus
Author: Mark Wilkie
Date: January 2024

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1 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines how agencies responded to, and supported, Barbara and Tom, who were residents of Southport, prior to their deaths in June 2021.

1.2 This report is unique in its format and approach to the death of Barbara, due to the overarching evidence that neither the criminal, coronial or DHR processes have identified any knowledge or indication of domestic abuse within the relationship prior to the couple's death. The report reflects agencies' involvement with Barbara and Tom, including contact during the COVID-19 pandemic.

1.3 Whilst the format of the report follows the principles contained within the Home Office Statutory Guidance[1], the structure has been adapted to reflect the circumstances of this case.

1.4 Tom and Barbara had been married for 50 years. They lived their whole married life at the same address in the Southport area. During their marriage, they had three children.

1.5 On a day in June 2021, one of their children went to Tom and Barbara's house and entered using their own key. They discovered the bodies of their mother and father in different rooms. Both were obviously dead and appeared to have been so for some time. The police and ambulance were called.

1.6 The police found a shotgun in the house; subsequently, a murder enquiry was initiated.

1.7 A Home Office post-mortem was conducted on both Tom and Barbara. The cause of death for Tom was identified as a shotgun wound to the head. The cause of death for Barbara was identified as a shotgun wound to the chest.

1.8 The police submitted a full report to the coroner's office, with the findings of the investigation. The conclusion was that there was no third-party involvement, and that the male killed the female and then killed himself.

1.9 The intention of the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.10 **Note:**
It is not the purpose of this DHR to enquire into how Barbara died.

2 Timescales

2.1 The first panel meeting took place on 29 March 2022. The report was concluded on 8 February 2023 following consultation with the family. Further information is contained at section 5.

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including their support worker, during the review process.

3.2 The report uses pseudonyms in order to protect the identity of the victim, perpetrator, and their children. The pseudonyms were chosen by the family.

4 Terms of Reference

4.1 The purpose of a DHR is to:

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;

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;

Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

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;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7).

4.2 Extensive research was undertaken with all agencies within the Sefton area – where the subjects of the review are known to have lived for over 50 years. This resulted in no knowledge of domestic abuse within the relationship. The DHR Chair contacted the Senior Investigating Officer, who confirmed that this was also the findings of the criminal and coronial investigation.

4.3 On 28 July 2022, the Sefton Safeguarding Partnerships' Lead contacted the Home Office and provided an update on the DHR. This stated that following extensive research, contact with the Senior Investigating Officer, and access to material gathered for the coronial investigation, domestic abuse had not been identified as a factor in the case. It was proposed that a concise overview report for the case, to capture the limited learning, would be produced and that the report would be available for the coronial processes due to take place later that year. The Home Office agreed with this course of action.

4.4 Specific Terms of Reference were not established for the review, due to the lack of information and contacts held by agencies. Additional information was requested from Merseyside Police to assist with background information. A summary of agency information is included within Section 6.

4.5 **Subjects of the DHR**
Victim: Barbara, 72 years

Perpetrator: Tom, 74 years

5 Methodology

5.1 Barbara was murdered in June 2021, and Tom, the perpetrator, took his own life at or around the same time. Merseyside Police informed Sefton Community Partnership. This fitted the criteria for a DHR, and the Home Office was informed. Sefton Council appointed Ged McManus as the Independent Chair in September 2021 but due to other commitments he was unable to start work on the review until March 2022. Thereafter, a DHR panel was assembled from agencies judged to be able to contribute to the review.

5.2 The panel did not set timescales for agency information; instead, they asked for all information available. For friends and family, information was sought about the lives of both Barbara and Tom, to build up a picture of their relationship.

5.3 The work of the panel was delayed by consultation with the coroner during which it was agreed that the DHR would take place before the inquest. A further delay was incurred due to the need for the police to seek legal advice around the disclosure of information to the DHR in these circumstances. Panel meetings were held via Microsoft Teams. The panel met four times – responses and additional queries, outside of these meetings, were addressed via telephone and email. The DHR panel carefully considered the material provided by agencies and the contributions made by the family. Following the DHR panel's deliberations, a draft overview report was produced, which was discussed and refined at further panel meetings. The work of the panel was concluded by December 2022. Consultation with the victim's family then took place before the conclusion of the review in February 2023.

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

6.1 The DHR Chair wrote to Barbara's youngest child, who was supported by a worker from the Victim Support National Homicide Service. Appropriate information and Home Office leaflets were included. They indicated through their National Homicide Service worker that they wished to be involved in the review. In June 2022, the Chair and Author met and spoke to them in person, when they were supported by their National Homicide Service worker. Their contribution is referenced appropriately throughout the review.

6.2 Merseyside Police provided the review with a summary of the statements collected in their murder investigation. This summary included members of the local community. Their personal details were not released, so they have not been seen by the Chair or Author.

6.3 The Author traced and spoke to other relatives and friends of Barbara and Tom. These included Barbara's half-sister, one of her bingo colleagues, and a member of Tom's fishing group. The information that they provided is incorporated into section 13, in an anonymised form. Nobody knew of, or suspected, any form of domestic abuse between the couple, and all were shocked at what had happened.

6.4 The Chair maintained contact with the National Homicide Service worker, during the review process, to support the family with relevant information and progress of the review.

6.5 Barbara was not employed at the time of her murder, or recently; therefore, no employer was able to assist the review.

6.6 Towards the end of the review, Barbara's youngest child was provided with a copy of the overview report and invited to provide feedback. They were supported in a meeting with the author by their National Homicide Service worker. They provided feedback on factual points which were subsequently corrected. They did not wish to attend a panel meeting.

7 Contributors to the Review / Agencies submitting IMRs

7.1

Agency	Contribution
Merseyside Police (MP)	Information from the police investigation
NHS Cheshire and Merseyside ICB Sefton Place	Summary of health records

7.2 The following agencies were written to as part of the scoping process for the review, but held no information on the victim or perpetrator prior to the incident:

- Merseyside Police
- Sefton IDVA
- Sefton MARAC
- One Vision Housing (not an OVH address)
- North West Ambulance Service
- North West Ambulance Service NHS 111
- RASA Merseyside
- Sefton Women's and Children's Aid (SWACA)
- Sefton Children's Social Care
- Sefton ASB Team
- Mersey Care NHS Foundation Trust
- National Probation Service

7.3 The agencies below had no records on the victim:

- Southport and Ormskirk Hospital

7.4 The agencies below have no records on the alleged perpetrator:

- Liverpool University NHS Foundation Trust – Aintree and Royal Liverpool Hospitals

8 The Review Panel Members

Ged McManus	Independent Chair
Mark Wilkie	Author and Support to Chair
Paul Grounds	Detective Chief Inspector, Protecting Vulnerable People, INV Command, Merseyside Police
Janette Maxwell	Locality Team Manager, Communities, Sefton Council
Dr Bryony Kendall	Named GP Sefton CCG
Neil Frackelton	Chief Executive Officer Sefton Women's and Children's Aid (SWACA)
Jacinta Ashdown	Chief Executive Officer Age Concern Liverpool and Sefton

Each panel member was independent – having no previous knowledge of the subjects nor any involvement in the provision of services to them.

9 Author and Chair of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, set out the requirements for review Chairs and Authors. In this case, the Chair and Author were separate people.

9.2 Ged McManus was chosen as the DHR Independent Chair. He is an independent practitioner who has chaired or written over sixty previous reviews, including DHRs, Safeguarding Adults Reviews and MAPPA reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Merseyside, Cheshire, or an adjoining area) and was judged to have the skills and experience for the role. He served for over 30 years in different police services in England (not Merseyside, Cheshire, or an adjoining area). Prior to

leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships, including Community Safety Partnerships and Safeguarding Boards.

9.3 Mark Wilkie, who wrote the report, served for 30 years within different police services in England (not in Merseyside, Cheshire, or an adjoining area). Prior to leaving in 2014, he was a Detective Superintendent who had been a Senior Investigating Officer, Force Authorising Officer, and Head of the Regional Intelligence Unit and covert operations. He chaired the local Serious Case Reviews. He has written and assisted in previous DHRs.

9.4 Both practitioners have completed online Home Office training and have attended accredited training for DHR chairs, provided by Advocacy After Fatal Domestic Abuse (AAFDA).

10 Parallel Reviews

10.1 An inquest was opened, but adjourned, immediately following Barbara and Tom's death. The cause of death for Tom was identified as a shotgun wound to the head. The cause of death for Barbara was identified as a shotgun wound to the chest.

10.2 Authority was granted by H M Coroner, for the Senior Investigating Officer to share relevant documentation – including statements from family and neighbours, and diary entries from Tom that had been gathered during the criminal investigation – with the Author to inform the DHR.

10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised: they should remain separate to the DHR process. There has been no indication in this review of any such process.

11 Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

Age (for example an age group would include "over fifties" or twenty-one-year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people

in their forties can share the characteristic of being in the "under fifty" age range).

Disability (for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act).

Gender reassignment (for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act).

Marriage and civil partnership (for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic).

Pregnancy and maternity

Race (for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens).

Religion or belief (for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be).

Sex

Sexual orientation (for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation).

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:
(a) P has a physical or mental impairment, and
(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 Barbara was a white British hetero sexual female. The panel considered whether Barbara could be classed as having a disability, as defined by Section 6 of the Equality Act 2010. There were no records held by agencies that indicated Barbara was disabled, within the meaning to the Act.

11.3 Tom was a white British hetero sexual male. The panel also considered whether Tom could be classed as a having a disability, as defined by Section 6 of the Equality Act 2010. There were no records held by agencies that indicated Tom was disabled, within the meaning to the Act.

11.4 At the time of their deaths, Tom and Barbara were living in an area that is predominantly of the same demographic and culture. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

11.5 Domestic homicide and domestic abuse in particular, is predominantly a gender crime, with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gendered differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018, according to the Office of National Statistics homicide report:

'There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner

Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims).
Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women).'

11.6 Whilst there is no evidence of pre-existing domestic abuse in this case, the panel acknowledged that research on domestic abuse and older people suggests that: 'older women's experiences of domestic abuse are markedly different from those in younger age groups and that these differences have not been adequately acknowledged or accounted for'.[2]

11.7 A report by Safelives, 'Safe later lives: Older people and domestic abuse', highlights that women aged 61 (40%) or over are more likely to experience abuse from a current partner than younger women (28%). They are also more likely to be living with the perpetrator after getting support – 32% for women 61 or over, 9% for younger women.

11.8 The Age UK report, 'No Age limit: The Hidden Face of domestic abuse', identifies that older victims face additional barriers to reporting.

Older survivors of domestic abuse can face significant barriers when asking for help or when trying to leave an abusive relationship. These barriers can be severe for survivors who have been subject to years of prolonged abuse, are isolated within a particular community through language or culture, are experiencing long-term health impacts or disabilities, or those who are reliant on their abuser for their care or money.

Research shows that older victims of abuse are likely to have lived with abuse for prolonged periods of time before seeking help. Physical health and dependency for others to care for them, as well as isolation, can all be factors in the decision made by older victims of abuse to remain in the relationship / home.[3]

[2] www.reducingtherisk.org.uk/cms/sites/reducingtherisk/files/folders/resources/victims/Domestic abuse_and_older_women_McGarry_and_Simpson.pdf 'Domestic Abuse and older women: exploring the opportunities…'

[3] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/id204298-domestic-abuse-a5-booklet.pdf

11.9 SafeLives Spotlight #1: Older people and domestic abuse (online)[4]

Page 13 of the Safelives report states:

'An additional key barrier that can arise in this client group is the issue of dependency. Older people are statistically more likely to suffer from health problems, reduced mobility or other disabilities, which can exacerbate their vulnerability to harm. Problems with physical health and subsequent isolation can present barriers to victims being able to access community services, as they may be unable to easily leave their home'.

12 Dissemination

Barbara's family
Home Office
Sefton CSP
H M Coroner
All agencies that contributed to the review
Merseyside Police and Crime Commissioner
Domestic Abuse Commissioner

13 Background, Overview and Chronology

13.1 Introduction

13.1.1 This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the family and punctuated by subheadings to aid understanding. The information is from documents provided by agencies and material gathered by the police during the homicide investigation. Quotes are taken from police statements that were disclosed for the purposes of the DHR. Analysis appears at section 14 of the report.

13.2 Barbara

[4] https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse

13.2.1 Barbara spent the first 18 years of her life living with her mother, in Liverpool, at a convent for unmarried mothers.

13.2.2 Whilst there, Barbara's mother worked in the laundry and was only allowed to see Barbara for a few hours a day. The nuns were described as being horrible to them – with the exception of one, who was kind and caring.

13.2.3 Both left the convent when Barbara reached the age of 18, with her mother meeting and marrying a local man. Barbara lived with them but never really accepted her stepfather.

13.2.4 It was not long before Barbara met Tom and married him. She had their first child at about the same time that her mother had her second child.

13.2.5 Barbara would visit her mother every weekend that she could: she was described as: **"*Bringing Joy to the house*".** Her mother was clinically depressed, which was believed to have been induced by the traumatic experiences from being in the convent. She never got over this, but Barbara provided support to her and her family throughout.

13.2.6 Barbara's mother died at the age of 53, leaving two children. Again, Barbara is described as supporting her stepfather and his two children: ***"So strong and in charge".*** She continued to be a big part of the family, helping her two much younger half-sisters.

13.3 Barbara and Tom

13.3.1 Nothing is known about the early life of Tom, other than that Tom met Barbara in 1968, at an open-air swimming pool in Southport.

13.3.2 They married shortly after conceiving their first child. They had two more children, whom they brought up at the family home where the couple died.

13.3.3 Tom worked for most of his life at a large international components company. He worked shifts, including nights. He was made redundant before retirement age. He then got a job at a supermarket, stacking shelves. He also went on to work as a gardener in the local area.

13.3.4 Barbara brought up the children and also worked as a part-time cleaner at a department store and then at a local public house. She was an avid bingo player. A friend said that she would finish work (cleaning) and then go

straight to the bingo every night; although, this routine was stopped when the COVID-19 restrictions came in and, indeed, the Bingo Hall closed down.

13.3.5 All three children moved out of the family home when they were young adults. Tom effectively became estranged from two of them after he asked them to leave when they made no attempt to get jobs; the couple did, however, maintain a good relationship with their youngest child. There was little to no contact with their two eldest children in the years before their deaths.

13.3.6 As a couple, they both worked together on their two allotments and helped other allotment owners: this help was reciprocated. There were times when the council would write to allotment owners about the state of overgrown vegetation: this was just regarded as something that happened from time to time and applied no more to Tom and Barbara than to other allotment owners.

13.3.7 Barbara and Tom would go out together, especially to the local Labour Club where they would have a drink and play bingo, when it was on.

13.3.8 Tom would also like to go out to the local pub without Barbara: he did this on a regular basis. That is until the COVID-19 restrictions came into place.

13.3.9 Tom was a shotgun certificate holder and kept his guns at their house. He was in the process of applying for a renewal for his certificate. However, the change to a digital system made this more difficult for him and he had to ask for help, from a friend and his wife, to complete the application online.

13.3.10 This renewal application was never completed, due to the death of Tom.

13.3.11 Tom had two main pastimes: shooting and fishing. He was a member of the Southport and District Wildfowling Association, where members would shoot wildfowl (mainly duck and geese). Whilst there are many club members, the actual sport is a solitary endeavour, as members shoot on their own.

13.3.12 Tom was also a member of a small group of men that would go out shooting wildfowl (mainly pheasant and wood pigeon) on the local marshes: this was a separate endeavour to the club. He would always be willing to give his friends some of the birds that he shot.

13.3.13 His other main pastime was fishing. He was part of another small group, of similarly aged men, who would fish from the local beach. He was described

as: "*totally reliable and one of a kind*". It was also commented that Tom was a mild-mannered man and never got wound up about anything. He spent hours, days, and months with these men.

13.3.14 Once, whilst fishing on the beach, Tom passed out. He was advised to go and see a doctor about this: it was believed that he did, as he told his friends he had anaemia. All his fishing friends knew that Tom had problems with one of his knees, as he had asked if he could borrow a knee brace from one of them.

13.3.15 Tom was due to have a knee replacement operation in November 2020; however, this was cancelled due to low haemoglobin.

13.3.16 It is of note that none of this group knew of his two eldest children. They were aware of his youngest child, and all knew Barbara.

13.3.17 When the COVID-19 restrictions came into force, the daily routines of both Barbara and Tom were severely disrupted. Tom and Barbara could no longer go out to the pub. Barbara could not play bingo and Tom was unable to continue shooting and fishing, as he had. This had a big impact on their lives.

13.3.18 From a neighbour's perspective, the couple appear to have lived quite separate lives. Neighbours who lived on the same street for many years, commented that they used to see Tom, but only occasionally saw Barbara. He would say 'hello' when passing but did not engage much in conversation. They rarely saw them together.

13.3.19 A resident on the street thought that they had noticed that Tom's health was failing: he appeared to be going deaf and his knee was playing up. They commented that he was "frustrated about growing old". The fishing group were also aware that Tom was going deaf, as he had asked if he could borrow one of their hearing aids.

13.3.20 The couple were described as hoarders, and this was reflected in the state of the property when the police attended. All the rooms were covered in clutter, with the front room being inaccessible due to a large number of personal belongings being piled up. It is quite likely, from information gathered, that it was Tom who was responsible for this. It was obvious that the couple slept in separate bedrooms, and this is corroborated by what others have said.

13.3.21 The police recovered diaries from the house. A review of the diaries belonging to Tom from 2020 and 2021, showed that Tom made daily notes of the new COVID-19 cases in the UK and the daily death rates of people in the UK. It also depicted that each week, Tom attended a cash machine and printed out a balance slip: it showed his state pension and work pension being paid into his account.

Tom appeared very meticulous in the filling in of his diary and rarely missed a day. He recorded all his medical appointments and daily events – to the extent of recording when he had a shower and cut his nails. He rarely mentioned Barbara in his diary, only referring to going out for a meal with her on the 23 April 2021, in which they attended the local Wetherspoons in Formby.

13.3.22 Their youngest child kept in regular contact with their mum and dad. When they could not see them, this contact was by text. However, the last reply from the texts was on 5 June 2021. Tragically, one of their siblings died during an operation, which prompted a visit to mum and dad's house to tell them. This is when the couple were found dead in their house.

13.3.23 Both Barbara and Tom had occasionally visited their local GP with age-related issues but not for anything that appears relevant to this review.

13.3.24 In June 2021, Barbara and Tom were found deceased at their home address.

14 Analysis

14.1 Firearms licensing

14.1.1 Tom was in possession of four shotguns: one of which he used to shoot Barbara and then himself.

14.1.2 The law states that you need a firearms certificate issued by the police to possess, buy, or acquire a firearm or shotgun.

14.1.3 When applying for a shotgun certificate, an applicant must also prove to the chief officer of police that they are allowed to have a firearms certificate and pose no danger to public safety or to the peace.

14.1.4 New guidance for firearms licensing, including arrangements for medical checks, came into effect in November 2021 (in England and Wales). This date is after Tom applied for his certificate but is included here to examine if it would have had any impact on the granting of his certificate.

14.1.5 The new statutory guidance on firearms licensing processes has been produced to reform and streamline the firearm and shotgun licensing processes, to ensure that these are consistent for police, medical professionals, and applicants.

14.1.6 From 1 November 2021, individuals wishing to apply for a firearms licence are now required to provide a completed medical proforma alongside their application to the police firearms licensing department.
The form should be completed and signed by the applicant's GP or another GMC-registered doctor, and while (in England and Wales) the applicant may then provide the form to the police themselves, it is preferred that the doctor sends it to the police directly.

14.1.7 It is the responsibility of the applicant to ensure that they provide evidence of all relevant medical suitability to possess a firearm. The guidance states that if the medical information provided to police is from a private practice, the private doctor must receive the applicant's medical information direct from the individual's usual NHS GP and not via the applicant.

14.1.8 The new guidance suggests that no one is granted a firearms certificate unless their doctor has confirmed to the police whether they have any relevant medical conditions, including in relation to their mental health.

14.1.9 Relevant medical conditions that must be disclosed are:

- acute stress reaction or an acute reaction to the stress caused by a trauma, including post-traumatic stress disorder
- suicidal thoughts or self-harm, or harm to others
- depression or anxiety
- dementia
- mania, bipolar disorder, or a psychotic illness
- a personality disorder
- a neurological condition: for example, Multiple Sclerosis, Parkinson's or Huntington's diseases, or epilepsy
- alcohol or drug abuse
- any other mental or physical condition, or combination of conditions, which you think may be relevant.

14.1.10 When a certificate is granted, or a person is registered as a firearms dealer, the police will contact the applicant's GP and ask them to place a firearms marker on their medical record. When reviewing patients, it is important to be aware of this marker and be reminded that the GP may need to notify the police should the patients begin to suffer from a relevant medical condition, or a relevant condition worsens significantly.

14.1.11 On 7 May 2021, Merseyside Police received a doctors' submission, with regards to Tom's certificate renewal. In the letter, the GP stated that Tom had no history of current or past medical conditions that would stop him from owning a shotgun certificate.

14.1.12 There does not appear to be anything in the new guidelines that would have led a GP to make a different decision, with regards to Tom's renewal application.

14.1.13 To make firearms licensing safer and the system quicker for practices, NHS Digital is introducing a standardised digital firearms marker in England. This marker matches relevant medical conditions against a firearms code: this then triggers an automatic flag to the doctor.

The panel was informed that this had not yet been rolled out within the GP surgeries and that this is a national, as opposed to local, issue.

14.2 **The panel asked Merseyside Police several questions in relation to Tom and their processes with regards to his licence. The questions and answers follow.**

14.2.1 **How long had he held a licence?**
Held since 1972.

14.2.2 **What exactly was he licensed for?**
Possess four shotguns.

14.2.3 **When was he visited at home?**
Last home visit was February 2016: there is no record of a requirement for a security check as no documented issues around mental health or lack of security of the firearms.

14.2.4 **When was his last application made and when was it approved?**

February 2016: this was due for renewal and Tom completed the online renewal on the 1 June 2021 – a face-to-face meeting had been arranged for 14 July 2021. The arrangement was made by email as there had been no contact with Tom.

14.2.5 **Were there any differences to the process because of COVID-19 regulations?**

Renewals were conducted over the phone during lockdown. There was a review of all licences granted during COVID-19 and home visits were arranged for when lockdown conditions allowed.

14.2.6 **Are Merseyside Police content with the firearms licensing issues? Did the process in this case meet your policy and standards?**

Yes, and Yes. There was a letter of recommendation from a suitable person as well as the doctor's notification.

14.3 **As the review progressed, the panel asked further questions of Merseyside Police in relation to the firearms process, which are detailed with answers below.**

14.3.1 **When was the last house visit?**

In 2016, a police officer attended to interview Tom. There were no references to the condition of the property. A further visit was due in 2021; however, this never materialised due to the incident.

14.3.2 **Was the condition of the premises recorded?**

No.

14.3.3 **Would the condition of the house impact upon the issue of the firearms licence?**

It can be a factor. If hoarding is recorded, an assessment is made, and mental health can be considered. It is important to note that this would not necessarily prevent a certificate being issued, it is merely a fact for consideration.

14.3.4 **Were there any future planned visits?**

A visit was due to be scheduled; however, this was not confirmed. A GP's letter had been received in 2021, in anticipation of the renewal and visit. This was a mandatory measure from the Chief Constable.

14.3.5 **Is there any recorded documentation, from visits, to share with the panel?**

2011 and 2016 visit notes were provided. There was nothing in the notes that assisted the review, other than the fact that there was no specific question on the renewal application regarding the condition of the home address of the applicant.

14.3.6 **Upon issuing firearms certificates, presumably the applicant's history is considered? Although Tom was not known to the police, if there had been any history of domestic abuse, would it have made any difference to the renewal of his firearms licence?**
This would be considered and is on a case-by-case basis, dependant on the applicant's history.

14.3.7 **Would the state of the house (hoarding) have had a bearing on whether or not the shotgun certificate would have been renewed?**
The current process is as follows.
If the Firearms Enquiry Officer (FEO) does a home visit and there is evidence of hoarding they do the following:

- Update Merseyside Rescue and Fire Service who have a "hoarders" list because of the fire risk.
- Advise the applicant on the issues around security. This is in terms of both the security of the firearm but also the fact they could be susceptible to criminality due to vulnerability.
- If appropriate, refer into Adult Social Care using the VPRF1.
- Refer to the Design Out Crime Officers who will liaise with the applicant around crime prevention and security advice.
- The application can be refused or revoked if necessary.
- Approved applications can be monitored where necessary.

14.4 Finance

14.4.1 There was no evidence presented to the panel of any financial control being exerted on Barbara by Tom. Both had bank accounts and it is known that Tom would make weekly withdrawals. The mortgage on the property had been paid off some years ago. No other details are known so it has not been possible to establish what the couple's financial arrangement was.

14.5 Agency Contact

14.5.1 Liverpool University Hospitals NHS Foundation Trust – Aintree and The Royal Hospitals

Barbara was seen at Aintree Hospital on three occasions by the Gastroenterology department for a Sigmoidoscopy, under the Bowel Screening Programme (Initially treated for Polyps) 2013, 2014 and 2017.

There are no records that Barbara ever attended The Royal Liverpool Hospital.

14.5.2 **Barbara's GP**

Registered at a local GP practice since 1968. Minimal GP contact and no entries in her primary care record to indicate any relevant problems. The Last GP contact was 26 February 2020.

14.5.3 **Tom's GP**

Registered at the same local GP practice as Barbara, since 1968.
Last GP contact was 9 November 2020: an urgent referral with dysphagia (swallowing difficulties). Hospital investigations did not reveal any sinister cause, but a stricture was found. A routine follow-up was arranged, which the patient was considering. No primary care entries to indicate any health concerns that are relevant to this case.

At the time of his death, Tom was prescribed Perindopril for Essential Hypertension Tension and Ferrous Sulphate for anaemia.

14.5.4 Medical records show that both Barbara and Tom attended the same medical practice for minor matters and that no concerns were ever noted, or raised, about any matters of abuse.

14.5.5 Arising from their involvement in this DHR, the GP practice reviewed their surgery case list to identify patients over 70, who have not had a health review for five years or more, to invite them for a health review appointment.

14.5.6 Social prescribing is quickly developing in Sefton.
Social prescribing is a way for local agencies to refer people to a link worker. Link workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support.

Link workers also support existing community groups to be accessible and sustainable, and help people to start new groups, working collaboratively with all local partners.[5]

The panel felt that the role of social prescribers was important in reaching out to, and connecting, potentially isolated people with community and statutory services.

14.5.7 The panel heard that social prescribers in Sefton would benefit from additional domestic abuse training to enable them to raise concerns appropriately. This is single agency learning for NHS Cheshire and Merseyside ICB Sefton Place.

14.5.8 **Southport and Ormskirk Hospital NHS Trust**
Tom had only attended Southport & Ormskirk NHS Trust for outpatient appointments. Tom last attended Southport and Ormskirk Hospital on the 19 January 2021, for an outpatient gastroscopy.

Tom was awaiting a knee replacement. However, due to a low haemoglobin (HB), this procedure was cancelled in November 2020 and Tom was referred back to his GP to investigate further.

14.6 **COVID-19**

14.6.1 The COVID-19 vaccination status of Barbara and Tom was as follows:
Tom
1st COVID-19 injection – 31/1/2021
2nd COVID-19 injection – 19/4/2021

Barbara
1st COVID-19 injection – 6/2/2021
2nd COVID-19 injection – 25/4/2021

Third boosters were only available after they had both died.

14.6.2 The lifestyles of both Barbara and Tom were disrupted by the rules introduced by COVID-19 legislation. For Barbara, she could no longer attend the bingo, and Tom could not go to the local public house to have a drink or go out shooting and fishing. This was their life and they struggled with the curbs on their activities.

[5] https://www.england.nhs.uk/personalisedcare/social-prescribing

14.6.3 This was combined with Tom starting to struggle with his mobility due to needing a knee replacement. The scheduled operation to replace his knee was cancelled in November 2020 and was never rescheduled before his death.

14.6.4 Domestic homicides didn't appear to increase dramatically during the pandemic – with 163 recorded in the 12 months to 31 March 2021. This was very similar to the previous year's figure of 152 and is in line with the 15-year average[6], according to the Domestic Homicide Project, Vulnerability Knowledge and Practice Programme (VKPP), NPCC, College of Policing.

14.6.5 The Project found that COVID-19 acted as an 'escalator and intensifier of existing abuse' in some instances, with victims less able to seek help due to COVID-19 restrictions. It also concluded that COVID-19 had not 'caused' domestic homicide, but it had been 'weaponised' by some abusers, as both a new tool of control over victims and – in some cases – as an excuse or defence for abuse or homicide of the victim.

14.6.6 **Homicide-suicide** (where the suspect died by suicide after murdering their partner). Of a total of 22 deaths involving homicide followed by suicide by the suspect, 13 of these victims were killed by an intimate partner. All 13 victims of intimate partner homicide followed by suicide, are suspected to have been murdered by a male partner. These intimate partner homicide-suicide cases fell into two broad patterns – (a) older males killing their female partners then themselves, where both partners were aged 65 years or older (7 cases, 54%); and (b) younger males (28 to 56) killing their female partners and themselves (6 cases, 46%).

With the older couples (a), none of the suspects were previously known to police for domestic abuse, and very little information was known about the history of the couple, in general. In three of these cases, the victim had chronic mental and/or physical health conditions, while one couple was known to mental health services, following reports that they had a suicide 'pact.' Overall, the six younger intimate partner homicide-suicide cases (b) included a varied history of high-risk domestic abuse perpetrated against a previous partner, recent separation, previous suicidality of the suspect, and previous attempts or threats to kill this, or a previous, victim. In three of

[6] Domestic Homicide Project, Vulnerability Knowledge and Practice Programme (VKPP), NPCC, College of Policing.

the younger intimate partner homicide-suicide cases, the victim was between 28 and 30 years old (suspect 28 to 34 years) and there was greater police knowledge about the suspects than within the older couples' cases (a).

14.7 Community support in Sefton during COVID-19 pandemic

14.7.1 The first national lockdown was announced on 23 March 2020. On the 24 March 2020, the Ministry of Housing, Communities and Local Government issued guidance to local authorities and the Merseyside Local Resilience Forum, about the Clinically Extremely Vulnerable People Service (VPS). This was set up as part of the Government's response to the pandemic, to provide support for clinically extremely vulnerable people who were advised to stay at home in England, otherwise known as shielding.

National support included delivery of basic food parcels and medicines directly to people's doorsteps and provision of priority supermarket deliveries; meanwhile, the local authority, working with partners across the voluntary and community sector, was asked to continue to care for those who might be experiencing social isolation and to provide social contact. On 16 April 2020, the Government NHS Digital Service (GDS) identified 7,373 households in Sefton that required support using NHS England Patient Data. Additionally, the Government National Shielding Service System (NSSS) allowed people to register for support, online and by telephone. Through these routes, during the initial lockdown (23 March 2020, and 31 July 2020), 21,372 Sefton households were identified in the shielding cohort, and 10,986 had requested support via the Government's National Portal and were referred to Sefton Council. A further 1,379 households directly contacted the local authority for support.

Sefton Council established the Sefton Communities and Vulnerable Persons Cell: a multi-agency working group. This cell set up a 'food-hub' and co-ordinated the delivery of emergency food parcels across Sefton to those shielding, who did not receive a delivery via national arrangements. It also visited all households that requested support but did not respond to the Government's attempts to contact them. In Sefton, over 48,000 social contact telephone calls were made to those shielding, and the 'GOV.Notify' system was used to send over 70,00 text messages to clinically extremely vulnerable people, reinforcing the support that was available to residents. Throughout the remainder of 2020, the local authority, with support from community partners, continued to actively contact and offer support with food and medicine deliveries, assisted shopping, supermarket priority

deliveries, and social befriending to those households where residents were clinically extremely vulnerable.

This localised support for clinically extremely vulnerable people continued as England entered the second national lockdown on the 5 November 2020, and again as a third national lockdown was announced on the 4 January 2021 – with the addition of dedicated COVID-19 engagement officers assigned to work in the community to echo the support available to residents self-isolating.

In January 2021, the first cases of the South African variant of COVID-19 were reported in England, and by 1 February 2021, the first reported case was identified in the north of the borough. Between the 4 and 19 February 2021, under Government instruction, the local authority mobilised a mass surge testing programme, targeting a specific geographic area in Southport. Staff visited 10,644 households and processed over 6,596 COVID-19 tests kits, to reduce the potential spread of the variant of concern in the area: this prioritised those previously identified as clinically extremely vulnerable people (who may have been choosing to self-isolate), to reduce their risks of infection.

Support continued throughout 2021 for those who were clinically extremely vulnerable and for residents who were self-isolating. This support included providing food and medicine deliveries, assisted shopping, social befriending, and advice and guidance on vaccination – with COVID-19 engagement officers targeting specific areas of the borough where uptake of COVID-19 vaccinations was low.

When restrictions eased, and it was safe to do so, activities such as lunch-clubs and coffee mornings were arranged, particularly through Brighter Living in Southport (one of the key partners of LWS).

14.7.2 Community support offered through Sefton Council for Voluntary Service [CVS]

Living Well Sefton (LWS) and Sefton CVS were engaged in the Sefton Communities and Vulnerable People's Cell that were initially held weekly and provided an update on case numbers that were being dealt with. Key themes identified were: financial support; food shopping and medicine delivery; online support; volunteering; and loneliness.

A referral form was created at the start of the pandemic in order for Sefton Council's Contact Centre staff to be able to refer residents into health and wellbeing support, via the Living Well Sefton (LWS) service, and a specific mailbox was set up for this purpose. Regular meetings took place with contact centre staff to talk about what was available and any trends in need.

14.8 Summary of CVS support available in Southport during the COVID-19 pandemic

14.8.1 Shopping

The shopping service was established in April 2020 to support vulnerable members of the community: this included free food provision if the client was particularly vulnerable or found to be in difficult circumstances. The shopping service was designed to focus on the shielded/clinical extremely vulnerable members identified within Sefton, but the parameters were flexible enough to support anybody who needed it. The service also supported shopping for several individuals who had been re-housed during the pandemic.

14.8.2 Befriending/wellbeing calls

The befriending service was set up in May 2020 to support people, particularly those on the shielded/clinical extremely vulnerable lists. Additionally, the Community Connectors support service offered a 'cuppa and chat' service online, if appropriate, for some clients. In addition to this, Sefton Women's and Children's Aid (SWACA) and Swan Women's Centre, both had their own befriending support services.

Wellbeing calls were completed by multiple partners of LWS, including the Brighter Living Partnership (BLP). Southport calls were shared between BLP and Community Connectors and were split geographically so they spoke to somebody with knowledge of the local area.

14.8.3 Prescriptions

Healthwatch established the prescription pick-up service across Sefton: referrals could be made by any professional for this. The service could support up to a certain level of medication (in terms of pick up and drop off) and continued to be managed by Living Well Sefton (LWS) until COVID-19 restrictions for clinically and extremely vulnerable people eased.

14.8.4 **Foodbank**

Foodbank referrals were moved to an online system rather than an in-person collection voucher. Food was dropped off by volunteers and there were some sessions that people could attend in person, if they wished to do so.

14.8.5 It is not believed that Christine and Tom used any of these services.

15 Conclusions

15.1 Barbara died as a result of an act of violence committed by Tom. The reasons behind this act are a matter for the criminal and coronial processes.

15.2 From the evidence and facts presented to the review, no one could have foreseen that Barbara would be murdered by Tom nor that he would take his own life.

15.3 At first, this review was thought to be unique in its circumstances, in that agencies had little, or no, contact with Barbara and Tom. However, the cited research by the Domestic Homicide Project found that between March 2020 and April 2021, there were seven cases where none of the suspects were previously known to police for domestic abuse, and very little information was known about the history of the couple in general.

15.4 The panel recognised that many domestic abuse incidents are never reported. One report, for example, states: 'On average victims experience 50 incidents of abuse before getting effective help'.[7] Nevertheless, prior to Barbara's death, there had been no indication of domestic abuse in the couple's long relationship. The panel was assured that there were no disclosures of domestic abuse in Barbara's interaction with medical professionals and there had never been any reports to the police of domestic abuse. No witness traced by the police, or the Report Author, was aware of any previous concerns about domestic abuse in Barbara and Tom's relationship.

15.5 The panel noted that whilst Tom continued to socialise with his shooting and fishing friends, Barbara may have been isolated. For example, neighbours rarely saw her outside the house. This may be a particular issue for older people.

[7] SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives

15.6 The Sefton Joint Strategic Needs Assessment shows that Sefton has a population of approximately 275,899, with 24% of Sefton's population being 65 years old or over (65,463). Sefton is ranked 24th out of 309 local authorities for the number of residents aged 65 or over. The Sefton Domestic Abuse Assessment states that:

The varying age demographics of different wards suggest that a tailored approach based on age may be required. For example, it is known that older people can be particularly vulnerable to certain forms of abuse, including abuse by a carer and financial abuse. Older people may be dependent on the person abusing them, which is a barrier to accessing specialist services. Staff working in areas with a high older person population will need additional training and awareness raising to ensure they are able to recognise all types of abuse.

Engagement with practitioners suggested that older victims of domestic abuse may also access services differently. Rather than accessing information online, they may prefer a physical 'drop-in' location.

16 Learning

16.1 **Narrative**

Sefton has a larger than average older population, which is particularly concentrated in some wards.

Learning

Older people such as Barbara, may be particularly prone to social isolation, which in turn may make them vulnerable to domestic abuse.

17 Recommendations

DHR Panel

17.1 Safer Sefton Together reviews the provision of community engagement and domestic abuse services – specifically targeted at older people in wards where the demographics show that this is priority.

17.2 **Single Agency – NHS Cheshire and Merseyside ICB Sefton Place**

Social prescribers in Sefton to be provided with domestic abuse training.

Appendix A – Action Plan

No	Scope of Recommendation	Scope	Action to Take	Lead Agency	Lead Officer	Key Milestones	Target Date	Date of Completion & Outcome
DHR Panel								
1	Sefton Domestic Abuse Partnership Board reviews the provision of community engagement and domestic abuse services – specifically targeted at older people in wards where the demographics show that this is priority.	Local	Review of current provision available Development of new/enhance service(s) Additional info/resources focusing on older people developed – aimed at highlighting the support and also for professionals around considering barriers to reporting/disclosure/additional needs	Sefton DA Board	Steve Martlew, Service Manager Communities, Sefton Council	Review of existing provision complete Service specification for additional service offer developed Service(s) commissioned Resources for professionals available Accessible public information available	Feb 2023 Aug 2023 April 2024 June 2023 Sept 2023	Review complete Feb 23 Existing provision has been reviewed through the completion of Domestic Abuse Needs Assessment (completed August 2022). This highlighted older people as a group with potentially unmet need. Support for older people is specifically referred to in Sefton's DA Strategy 23-27. At Jan 24 - Ongoing work around developing additional services and resources, in conjunction with Sefton Adult Safeguarding Board and Adult Social Care.

No	Scope of Recommendation	Scope	Action to Take	Lead Agency	Lead Officer	Key Milestones	Target Date	Date of Completion & Outcome
NHS Cheshire and Merseyside ICB Sefton Place								
1	Social prescribers in Sefton to be provided with domestic abuse training.	Local	Sefton Social Prescribers to receive domestic abuse awareness training	NHS Cheshire & Merseysi de ICB Sefton Place	Associate Director of Primary Care and Integration	Training commissioned Information on training delivered provided – numbers attending, participant feedback	Sept 2023	Complete April 2023 SWACA delivered domestic abuse awareness training to 20 people from the North and South Social Prescribers employed by Sefton CVS.

Please note: the action plan is a live document and subject to change as outcomes are delivered.

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12 December 2023

Dear Janette,

Thank you for submitting the Domestic Homicide Review (DHR) report ('Barbara') for Sefton Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 8th November 2023. I apologise for the delay in responding to you.

The QA Panel is grateful for your report on what was clearly a challenging case and notes the lack of evidence of ongoing domestic abuse and lack of contact with the police and other agencies which would usually feed into a DHR. A comprehensive review of the shotgun licence has been conducted which is helpful to understand and the review has done well to try and identify any abuse and learning about isolation of older people, exacerbated by the pandemic.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- There is a general point that the cause of death should be described as consistent with the coroner's report. Terms such as 'homicide' and 'murder' may not be appropriate in the absence of a criminal conviction.

- The gap between the homicide in June 2021 and the appointment of the Chair in March 2022 is not explained. The Data Collection Sheet shows that the Home Office was not notified of the DHR until eight months after the homicide. This is not explained.

- Under Section 11, for consistency it may be helpful to include a couple of lines of explanation about ‘Sex’ in line with the explanations under the other diversity headings.

- Paragraph 13.3.6 - The Panel queried why there was a reference that ‘There were times when the council would write to allotment owners about the state of overgrown vegetation: this was just regarded as something that happened from time to time.” It may be helpful to make clear that this applied to Barbara and Tom, but no more than to other allotment owners?

- The acronym “CVS”, appearing four times in the Overview Report is not explained.

- Paragraph 13.3.21 - In terms of anonymity, it may be helpful to remove the specific date of the final diary entry, as this may point to the date of the deaths.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel