Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Judith
in August 2017

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January 2019

Contents

1 The Review Process

1.1.1 This summary outlines the process undertaken by the Bassetlaw, Newark and Sherwood Community Safety Partnership Domestic Homicide Review Panel in reviewing the death of one of its residents. The death occurred in August 2017.

1.1.2 The following pseudonyms have been used in this review to protect the identity of the victim and her family members:

Judith was 59 years old at the time of her death and she was white British
Frank was 58 years old and was of dual heritage, with his father being Pakistani and his mother being white British

1.1.3 Frank was charged with Judith's murder and pleaded guilty to manslaughter on the grounds of diminished responsibility. The court accepted that at the time of the incident Frank was suffering a depressive illness that severely impaired his reasoning resulting in temporary loss of self-control. In August 2018 he received a prison sentence of 9 years and 4 months.

1.1.4 The process began with an initial meeting of the Community Safety Partnership on 13th October 2017 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Judith or Frank prior to the murder were contacted and asked to confirm whether they had any involvement with them. Agencies that had some involvement were asked to secure their files.

2 Contributors to the review

2.1 The following agencies and individuals contributed to the review:

- Newark and Sherwood District Council
- Nottinghamshire Police
- Nottinghamshire County Council
- Nottinghamshire Healthcare Trust
- Newark and Sherwood Clinical Commissioning Group
- Nottinghamshire Women's Aid
- Family of Judith and Frank
- Close friends of Judith and Frank

3 The Review Panel Members

3.1 The Panel was made up of the following members:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Ros Theakstone	Director of Corporate Resources	Bassetlaw District Council
Ben Adams	Community Safety Manager	Newark and Sherwood District Council
Nicolette Richards	Domestic Abuse Officer	Newark and Sherwood District Council

Justine Wilson	Detective Chief Inspector	Nottinghamshire Police
Clare Dean	Detective Chief Inspector	Nottinghamshire Police
Tina Hymas-Taylor	Head of Safeguarding	Sherwood Forest Hospital Trust
Naomi Russell	Group Manager, Younger Adults	Nottinghamshire County Council
Jo Foley	Children's Services Manager	Nottinghamshire County Council
Sally Cope	Group Manager Younger Adults South Nottinghamshire	Adult Social Care Nottinghamshire County Council
Julie Gardner	Associate Director Social Care	Nottinghamshire Healthcare Trust
Mandy Green	Head of Services	Nottinghamshire Women's Aid
Hannah Hogg	Corporate Safeguarding Lead	Nottinghamshire Healthcare NHS Foundation Trust
Sue Barnitt	Head of Quality and Adult Safeguarding	Newark and Sherwood Clinical Commissioning Group

4 Chair and Author of the Overview Report

4.1 The review was undertaken by Gary Goose and Christine Graham. Gary Goose chaired the review, the investigations were undertaken by both Gary and Christine and the report was written by Christine Graham.

4.2 Christine and Gary are independent of, and have no connection with, any agencies in the Bassetlaw, Newark and Sherwood Community Safety Partnership or the county of Nottinghamshire.

5 Terms of Reference for the Review

5.1 According to the statutory guidance the purpose of the DHR is to:

- Establish the facts that led to the incident in August 2017 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in August 2017; suggesting changes and/or identifying good practice where appropriate.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

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

- Highlight good practice.

5.2 The panel agreed that the specific purpose of the review is to:

- Seek to establish if the events in August 2017 could have been reasonably predicted or prevented.

- Consider the period of two years prior to the events (unless there are significant incidents prior to this date), subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

- Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

- Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

    - guidance from the police as to any sub-judice issues,
    - sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

6 Summary of the chronology

6.1 **Background information**

6.1.1 Judith was a white British woman and Frank was of dual heritage (his father being Pakistani and his mother being white British). They had been in a relationship for 30 years. At the time of her death Judith was 59 years old. She had one brother. They had one child with profound and multiple learning difficulties. Frank was 58 years old at the time of the incident. He had two children from an earlier marriage, one of whom had lived with Frank and Judith and considered Judith to be his mother.

6.1.2 The couple had been foster-carers for a number of years fostering many children over the years until they decided to withdraw from the service in 2009. Many of those fostered by Judith and Frank were teenagers presenting with very difficult behavioural issues and learning disabilities. The couple remained in close contact with a good number of them. There is no doubt that both Judith and Frank contributed hugely to the lives of others.

Judith's brother described them as a 'formidable team' who had left a great legacy in the restored lives of many teenagers.

6.2 **The months leading up to the incident**

6.2.1 The transition of their child from children's social care to adult social care was of increasing concern to the couple as the time approached for her to leave the schooling provided which occupied a significant proportion of her time. The family were referred to the Transitions Team (Nottinghamshire County Council) in September 2015 in order that arrangements could be made for their child's transfer when she became 18. Over the following months, discussions were held with the couple and, at the time of the incident, arrangements had been made for her day to day provision, but respite care had not been resolved as the couple were not happy with the provision that had been suggested.

6.2.2 In August 2016 Frank attended his GP due to stress and trouble sleeping. According to his GP records, he did not have any thoughts of deliberate Self Harm and was prescribed with short term medication to be taken as needed. Frank's recollection of this consultation is that he told the GP that he was feeling suicidal.

6.2.3 Frank was reviewed by the GP on 15th September but there is nothing in the records to suggest that the previous concerns about stress were discussed by the GP or raised by Frank.

6.2.4 In July 2017 Judith, Frank and their child all holidayed on an island in the Scottish Highlands with two other couples who they had known for many years. Frank is described by all as being in low mood and becoming obsessed with minor issues. This was so noticeable that Judith and the friends discussed together the best way of approaching Frank about it. One of the closest friends travelled back from holiday with Frank and asked him about it when staying with him overnight at another family member's home.

6.2.5 Frank attended his GP on 1st August 2017. The GP recorded that Frank stated that he was experiencing increasing anxiety, night time waking and was 'a bit low in mood' and it is documented he had no thoughts of deliberate Self Harm. Frank told the review he had said that this was the worst he had ever felt.

6.2.6 Frank was seen by the same GP a week later when he said he had not been taking his diabetic medication for a long time due to anxiety. He was advised to recommence his medication.

6.2.7 **The day of the incident**

6.2.8 Just after 5pm on 12th August Frank dialled 999 and reported that he had killed his partner. During this call he confirmed that she was dead, saying that he had waited until she had died before he had called. He asked the 999 operator to get the police to go to the house as he had left his disabled child there alone. During this call he said he would make his way to the police station.

6.2.9 Having begun the call he walked in the direction of Newark Police Station. Officers attended the address where they found their child in the living room and Judith was lying face down on the settee. No pulse was found, and CPR was commenced. Paramedics arrived and despite their efforts, Judith was pronounced dead. A rolling pin and knife, both covered in blood, were found in the lounge area.

6.2.10 Frank remained on the telephone during this time and officers located him in the street and he was arrested on suspicion of murder.

6.2.11 Whilst in custody, Frank said that he had intended to kill Judith, his child and then himself but that, having killed Judith, he could not continue with the plan.

6.2.12 Following a post mortem it was concluded that Judith had received eight stab wounds to her back. Whilst these were significant, they did not directly result in her death. She also suffered multiple blunt force injuries to her head which resulted in nine lacerations and a significant skull fracture. It was noted that there were no defensive injuries to the body.

6.2.13 On 28th March 2018 the Crown accepted a plea of guilty to manslaughter on the grounds of diminished responsibility. Frank had been subject to medical reports by three psychiatrists and there was consensus that at the time of the incident he had been suffering from a depressive illness that resulted in a temporary loss of self-control.

6.2.14 At a sentencing hearing on 17th August 2018 the judge ordered that he serve his sentence in prison, rather than receive a hospital order. The starting point for the sentence was 14 years' imprisonment. Given his good character and full credit for a guilty plea and his co-operation in the investigation, this was reduced to 9 years and 4 months and he would serve half of this sentence in prison.

6.3 Information from family and friends

6.3.1 The review is very grateful to those who have contributed to the review. Several direct relatives of Frank and Judith, their partners, together with long standing friends of both Judith and Frank have fully engaged with the process. It has enabled us to form a picture of Judith, a woman who was loved and admired by many. Judith and Frank had been together for thirty years and therefore she was considered to be part of Frank's family. Thus, when his brothers and sister-in-law have talked about Judith and Frank they have spoken about her as if she were a member of *their* family.

6.3.2 This review has also spoken with the perpetrator. He made it perfectly clear at the beginning of the meeting with him that he was fully responsible for what had occurred. He did not want anything said that in any way could suggest that Judith had contributed to her own death but remained at a loss as to why he had done what he had done. He openly discussed the relationship, the fundamental disagreement over their child's care and accepted that he had not been forceful enough in addressing his deteriorating mental health.

6.3.3 Judith has been described as 'the most loyal, caring and selfless person' that people had ever met. She always put others, especially their child, ahead of herself. She had a real sense of justice – of right and wrong. Judith was a woman who could stand up for herself and others.

6.3.4 Judith and Frank were described by all members of the family as being the ones that everyone turned to when they needed help and support. Every person we spoke to could relate a time when Frank and Judith had either had them to stay for an extended time or had gone to visit them regularly to support them through a difficult time.

6.3.5 Judith and Frank were very active. They would go out for walks and days out and often went away in their caravan, taking their child and other family and friends with them. Frank would

cycle up to 60 miles and pick up litter on his many walks. They often went swimming and out for meals.

6.3.6 Everyone described Judith and Frank as being incredibly close. They did bicker and argue described in a way as some couples do in a relationship.

6.3.7 Frank was described by everyone as a very intelligent man. He was very active and managed his diabetes, until the final months before the incident, by exercise and diet rather than taking medication. He was considered by some professionals to be verbally aggressive, but all of his family put this down to him being hard of hearing and his passion about subjects. No-one described him as physically aggressive. He was known to stand up for what he believed to be right and the review heard numerous examples of how he and Judith had advocated on behalf of the young people in their care to achieve a better outcome for them.

6.3.8 Family and friends were able to talk about changes that they had seen in Frank just prior to the incident and these are discussed in more detail in the full report.

7 Key issues arising from the Review

7.1 **Evidence of domestic abuse**

7.1.1 There were no reports of domestic abuse by Judith to any agency prior to her death. All of those who were spoken to, and records reviewed, uncovered no evidence to suggest that their relationship was in any way abusive. However, there is information uncovered during the police investigation that has led the review to examine again if there was any abuse prior to the final incident.

7.1.2 During the sentencing hearing, reference was made to Frank having 'slapped' his first wife. Frank's sister has said that she was there when this happened, and she does not consider it to be a significant event and was prompted by an argument between her and other children in their care.

7.1.3 As part of the police investigation, Judith's laptop was recovered, and, on this laptop, a number of recordings were found. It appears that Judith recorded programmes from the radio and made recordings of her reading to their child on the laptop. Two recordings were recovered which were made in April 2017, four months before the incident. The first takes place whilst Judith was reading to their child and is a four-minute extract of an argument between her and Frank. These are discussed in detail in the full report.

7.1.4 Despite exhaustive enquiries by the police there has not been any evidence from any source to corroborate or support the view that this argument is indicative of years of an abusive relationship. We cannot know categorically the level of domestic abuse, if any, that Judith was subject to and the suggestion of ongoing domestic abuse has been difficult for the family and friends to come to terms with. Everyone that the review has spoken to has said that they never witnessed anything other than a loving relationship between Frank and Judith, apart from usual day-to-day bickering. Different people had been swimming with the family on numerous occasions and had never seen any bruises or marks on Judith. Her friends believed that their relationship was such that Judith, could and would have told them if she were experiencing abuse.

7.1.5 The evidence that prior domestic abuse existed within this relationship thus remains inconclusive. Despite all the enquiries made by police and the additional work carried out by this review, no information has been obtained to support the very stark inference heard in the aforementioned recording. Frank killed Judith, an inescapable fact and the most final of all acts of domestic violence; it could be argued that this in itself is evidence that supports its content. However, all of the avenues that can be normally expected to provide the real context of a relationship add nothing to that point of view.

7.2 **The impact and responsibility of the couple acting as carers**

7.2.1 The part that their child played in the family is significant to the time leading up to Judith's death and, for this reason, she will feature within this review. She was described as a young person with profound and multiple learning difficulties.

7.2.2 One issue of their child's care caused what has been described by several people, including Frank, as an ongoing tension between them. In fact, the evidence would seem to suggest that this issue was at the core of any other disagreements they would have had. Judith had very strong views about the use of medication in relation to sedating children with disabilities. Her brother said this developed in her teens when she volunteered helping children with disabilities and witnessed what she described as a 'medical cosh' given to those children to help them sleep. It seems that Judith felt this was often given more for the benefit of the carers than the child; she was vehemently opposed to its use. She had trouble sleeping and this in turn meant that sleep was almost always disturbed for Judith and Frank. Whilst it appears that Judith was able to cope with this, Frank struggled. He struggled to the point that at times he would go to a nearby house that they owned, to sleep there. Medication had been prescribed to help her sleep, but Frank said that Judith often failed to give it or would only give part of the dose and he says that he found medication hidden in the bin. This issue caused an ongoing tension and there is no evidence that they sought advice about it, rather they tried to deal with the issue themselves.

7.2.3 The review has heard from family and friends that the transition from children's services to adult services was a stressful time for the family. During interview, after his arrest, Frank told police that the pressures had increased after she turned 18 years old. He told them that all the respite care ceased overnight and that this was now 'biting'. He told police that the respite care was extremely important, and that Judith coped with the situation very well, but he could not find a way out.

7.3.4 The review has been struck by the care and dedication that both Judith and Frank gave to their child throughout her life, always looking to expand her horizons and give her as many positive experiences as possible. Many people have talked to the review about them taking her out and away on holiday.

7.4 **Frank's mental health**

7.4.1 We know that had a history of attending his GP spasmodically about his mental health. The most recent visit to the GP was two weeks before the incident.

7.4.2 Frank attended his GP on 1st August 2017 and his GP's record states that he was experiencing increasing anxiety, night time waking and was 'a bit low in mood' and again he said he had no thoughts of Deliberate Self Harm. Frank recalls that he told the doctor that he felt like he was 'going through glue' and felt worse than he had ever done before. He

thought that the GP would infer from that statement that he was feeling suicidal again. Frank is clear, when he recollects this consultation that he had a responsibility to tell the GP that he was feeling suicidal.

7.4.3 Frank talked at great length about his state of mind in the weeks leading up to the incident and describes that he stopped taking his diabetes medication because he did not care, and he just wanted to die. He said that his brain was telling him that life was not worth living.

7.4.4 Those who have spoken to the review have all talked about a change in Frank in the recent years leading up to the incident that was out of character for him. He became snappy and argumentative and would become fixated on a topic, becoming worked up about things that were not important. On one occasion, he had called a close friend as he was very concerned about some financial matter and, in the view of the friend, he was disproportionately worried about this.

7.4.5 Three weeks before the incident, Judith and Frank holidayed with close friends as they had done many times over the years. During the holiday, the friends noticed that Frank was not his usual self. At the end of the holiday, one of the friends drove Frank and Judith home and stayed overnight with them. The next morning, they had a long conversation together about how Frank was feeling. Frank admitted that he was not great and was worried and anxious about all sorts of things.

7.4.6 We know that, in the days leading up to the incident, Judith and other family members were becoming increasingly concerned about Frank.

7.4.7 The sentencing hearing was told that Frank was suffering from a depressive illness that severely impaired his reasoning at the time of the incident. He suffered a temporary loss of self-control. Although Frank was depressed, he was not, however, psychotic. There was a level of pre-meditation in the act as the rolling pin and knife had been taken into the living room.

7.4.8 One of the issues that has been very clear as we have talked to Frank and his family is the reluctance on the part of Frank to talk about his mental health. Frank says that because of his generation and background he could not talk about his mental health. It has been very clear from recent coverage in the media that men can find it very difficult to talk about their mental health. This may be for a variety of reasons:

- That it is seen as a sign of weakness
- That a man should be able to control his feelings
- That men should not ask professionals for help
- That talking about it won't help
- That it will make you a burden to others

7.4.9 It is also very clear that Frank, as the 'head' of the family was the man who sorted out everyone's else's problems, who people came to for help. This made it very difficult for him to talk about how he was feeling.

8 Conclusions

8.1 At the conclusion of the criminal trial the judge, in his sentencing remarks, described the outcome as 'a tragedy'. He said that there was no real reason why it happened, it was unnecessary, it was avoidable, Frank knew he was feeling unwell and had a supportive network of family, friends and health professionals who he could have turned to.

8.2 This review has considered in depth whether domestic abuse was a feature of this relationship and, if so, when and why it developed and the role it played in Judith's death. Given all that we have learnt this review is unable to conclude whether prior domestic abuse was present or not. There was no evidence available to agencies to suggest that domestic abuse was a feature of their relationship.

8.3 The impact that Judith and Frank had on many young people's lives cannot be understated. They changed the lives of many people for the better.

8.4 Frank had a supportive family and it is truly a tragedy that he did not feel able to turn to them for help.

8.5 The review panel extends its sympathies to the family and friends.

9 Recommendations from the review

9.1 GP practices should ensure that there are robust processes in place for monitoring the collection of prescribed medication and consider the impact of non-concordance of those with caring responsibilities

9.2 When identified carers disclose mental health conditions such as stress, anxiety and low mood conversations should occur with the patient as to whether additional support is needed. Whilst this has arisen from the particular review, we feel that this recommendation and its context should be brought to the attention of all organisations supporting carers across the County and thus this review should be sighted by the County's Adult Safeguarding Board.

9.3 The suppliers of the Systmone system make the necessary upgrade to provide a WNB code and this is communicated to all users of the system, along with the reasons for using this new code. This is a national recommendation for NHS Digital (via the Department of Health) as the Panel feel that all users of Systmone would benefit from this additional code.

9.4 Where patients do not have the capacity to bring themselves to appointments as they are dependent upon carers, GP practices should ensure that there is a robust process for following up non-attendance for required health checks.

9.5 The CCG should work with primary care services to develop a carers' charter which practices could use to support implementation of best practice for offering support to individuals who identify themselves as carers

9.6 (National) It is recommended that public health bodies are asked, through the Department of Health, to consider promotion around how people can access support if they are

concerned about a family member. For example, posters about how women encourage men in their lives to access support if they are showing symptoms of prostate cancer.

Whilst Recommendations Four and Five have arisen from the particular review, we feel that these recommendations and their context should be brought to the attention of all organisations supporting carers across the County and thus this review should be sighted by the County's Adult Safeguarding Board.