DHR W04 2020

Domestic Homicide Review

into the death of a lady

"Poppy"

aged 80 years

in February 2020

Report by: Malcolm Ross M.Sc

Date: 13th June 2022

Testimony by Family

Testimony written by son, and partner

Tea, Toast & Toilet; that was my Mom's happy, just to be surrounded by nature,flowers & simplicity.
Whatever we did, wherever we went "3t's" would always happen, always be laughter, Always be fun, no frills ~ no fuss nothing a loving natter couldn't fix.

I've tried, but still can't get the right words to sum up Mr ……. even now.
Proud ~ Private ~ Pain in "bum" ~ but that was my Dad. We all lost count of the timeshe'd laugh when saying I've crashed my car into the garden wall again.
Intelligent, a NHS electrician, health & safety through & through.

61 years of marriage, so many plans we had together that won't be finished, myDad ~ my Mom's murderer.

Contents

List of Abbreviation

A&E	Accident and Emergency Department (Hospital)
AMHP	Approved Mental Health Practitioner
CCG	Clinical Commissioning Group
CCJW	Christian Congregation of Jehovah's Witnesses
CRCCG	Coventry and Rugby Clinical Commissioning Group
CSP	Community Safety Partnership
CT Scan	Computed Tomography Scan
CWPT	Coventry and Warwickshire Partnership Trust
DASH	Domestic Abuse, Stalking and Harassment assessment
DHR	Domestic Homicide Review
FACS	Fair Access to Care Services
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IMRs	Individual Management Reviews
MAPPA	Multi Agency Public Protection Arrangement
MARAC	Multi Agency Risk Assessment Conference
NHS	National Health Service
SWCCG	South Warwickshire Clinical Commissioning Group
SSWCSP	Safer South Warwickshire Community Safety Partnership
SWFT	South Warwickshire NHS Foundation Trust
WCC	Warwickshire County Council
WAHT	Worcestershire Acute Hospital NHS Trust
WNCCG	Warwickshire North Clinical Commissioning Group

SAFER SOUTH WARWICKSHIRE COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review

into

the death of a lady, Poppy, age 80 years

in February 2020

The Domestic Homicide Review Panel express their sincere condolences to the family of Poppy who died in February 2020 and of Dad who died in April 2020, whilst in hospital.

The son of Poppy and Dad, and his partner, have chosen the pseudonyms. The wife and husband will be referred to by those names throughout this report.

1. Introduction

1.1.1 This Domestic Homicide Review (DHR) deals with the death of an 80 year-old woman, Poppy, who was fatally injured at her home by her 82 year old husband, Dad, in February 2020. A Police investigation commenced and Dad was arrested and charged with her murder. It was deemed that he was too unwell to be remanded in custody and was transferred to a local hospital. His health deteriorated significantly and in April 2020, he died of natural causes whilst in hospital.

1.1.2 Safer South Warwickshire Community Safety Partnership (SSWCSP) was informed by Warwickshire Police of the circumstances of Poppy's death and a Domestic Homicide Review was commissioned by the Community Safety Partnership after consultation with the Home Office on the 19th March 2020. The Senior Coroner for Warwickshire was informed of these circumstances and held an Inquest into Dad's death in April 2021 and an Inquest into Poppy's death on 28 April 2021.

1.2 Purpose of the Review

1.2.1 The Domestic Violence, Crime and Victims Act 2004 establishes at Section 9 (3) a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011 and reviewed in December 2016[2]. Under this section, a Domestic Homicide Review means a review "*of the circumstances in which the death*

[1] [1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*

[2] [2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b)a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death"

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013 the Government introduced a new cross Government definition of Domestic Violence and abuse[3], which is designed to ensure a common approach to tackling Domestic Violence and abuse by different agencies. The definition states that Domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

1.2.5 In December 2016, the Government again issued updated guidance on Domestic Homicide Reviews especially in deaths resulting in suicide. The guidance states[4]:

'Where a Victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.'

1.2.6 The circumstances of Poppy's death met the criteria of the guidance in that her death was caused by an act of violence by a person by whom she was in an intimate personal relationship with, Dad.

1.2.7 Such reviews are not enquiries into how Poppy died or who is to blame. These are matters for the Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of the review is to:

[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.
[4] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance paragraph 18 page 8

- Establish what lessons are to be learned from the 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 the policies and procedures as appropriate; and

- Prevent domestic homicide and improve service responses for all Victims and their children through improved intra and inter-agency working.

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

- Highlight good practice

1.3 Time Period

1.3.1 The period of this review will be from 1st January 2014 (the date that the health of both Poppy and Dad started to deteriorate) to the end February 2020, (nearly 2 weeks after the death of Poppy). The scoping of this review began with an initial scoping exercise in March 2020, prior to the first virtual/online Panel meeting on 14th May 2020.The scoping exercise was completed by SSWCSP to identify agencies that had been involved with the family. Where there were no involvement or insignificant involvement agencies were requested to inform the review by a report. An individual management report (IMR) was requested in all other circumstances.

1.4 Confidentiality

1.4.1 Information gathered during the course of this review was shared with Panel members, family members and their Advocate from the National Homicide Service of Victim Support, the Community Safety Partnership Board and the Home Office. All Panel members respected the need for confidentiality.

1.5 Methodology

1.5.1 The Safer South Warwickshire Community Safety Partnership (SSWCSP) was notified of the death of Poppy by Warwickshire Police in February 2020. The SWCSP reviewed the circumstances of this case against the criteria set out in Government guidance[5] and contacted the Home Office for advice on 19th March 2020. The advice from the Home Office was the circumstances met the criteria and a DHR was justified.

1.5.2 An Independent Chair and Author was commissioned on Friday 1st May 2020, and a DHR Panel was identified. At the first Review Panel meeting terms of reference were agreed.

1.5.3. Home Office Guidance[6] recommends that reviews should be completed within 6 months of the date of the decision to proceed with the review. The Community Safety

[5] Home Office Guidance 2016 Page 9

[6] Home Office Guidance 2016 page 16 & 35

Partnership (CSP) has attempted to conform to this timescale.

1.5.4 On 5th February 2021, the SWCSP approved the draft version of the overview report and its recommendations, although there were some amendments to the report furtherto input from the Christian Congregation of Jehovah's Witnesses.

1.6 Contact with family and friends

1.6.1 Home Office guidance[7] requires that

> 'Consideration should be given at an early stage to working with Family Liaison Officers and Senior Investigation Officers involved in any related Police Investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide.'

1.6.2 The 2016 Guidance[8] illustrates the benefits of involving family members, friends and other support network as:

> a) assisting the family with the healing process which links in with Ministry of Justice objectives of supporting Victims of crime to cope and recover for as long as they need after the homicide;
>
> b) giving family members the opportunity to meet the Review Panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process to focus on Victims and Perpetrator's perspectives rather than just agency views.
>
> c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.
>
> d) enabling families to inform the review constructively, by allowing the Review Panel to get a more complete view of the lives of the Victim and/or Perpetrator in order to see the homicide through the eyes of the Victim and/or Perpetrator. This approach can help the Panel understand the decisions and choices of the Victim and/or Perpetrator made.
>
> e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information as well as testimony to the emotional effect of the homicide. The Review Panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.
>
> f) revealing different perspectives of the case, enabling agencies to improve service design and processes.
>
> g) enabling families to choose, if they wish, a suitable pseudonym for the Victim to be used in the report. Choosing a name rather than the common practice of

[7] Home Office Guidance 2016 page 18
[8] Home Office Guidance 2016 Pages 17 - 18

using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

1.6.3 Comments made by the family members have been included. Warwickshire Police made a referral to Victim Support who have been engaged with the son of the family and have supported family involvement in this review. Details of the family's accounts are referred to in this report. Please see section 'Views of the Family'.

1.6.4 Family members have been supplied with a redacted copy of the Overview Report and the Executive Summary of this report.

1.7 Contributors/Individual Management Reports

1.7.1 An Individual Management Report and comprehensive chronology was requested from the following organisations:

- South Warwickshire CCG for Primary Care
- Coventry and Warwickshire Partnership Trust
- Warwickshire Police
- South Warwickshire NHS Foundation Trust
- Worcestershire Acute Hospitals NHS Trust

1.7.2 Reports of information were provided by:

- Housing (Orbit Housing)
- Adult Social Care

1.7.3 Guidance[9] was provided by IMR Authors through local and Statutory Guidance and through an Author's briefing. Statutory Guidance determines that the aim of an IMR:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standard
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

1.7.4 Agencies were encouraged to make recommendations within their IMRs and these were accepted and adopted by the agencies that commissioned the reports. The recommendations were supported by the Overview's Author and the Panel.

1.7.5 The IMR reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons learned.

1.8. **Review Panel**

1.8.1 In accordance with the statutory guidance, a Panel was established to oversee the process of the review. Mr Ross chaired the Panel and attended as the author of the Overview Report. Other members of the panel and their professional responsibilities were:

[9] Home Office Guidance 2016 Page 20

- **Karin Stanley –** Stratford CSP Lead

- **Jim Essex** – Police Staff Manager Statutory & Major Crime Review Unit (SMCRU) Warwickshire Police
- **DC Sarah Williams** - SMCRU (Statutory and Major Crime Review Unit)

- **Maxine Nicholls** - Lead Professional for Safeguarding Adults South Warwickshire NHS Foundation Trust
- **Julie Vaughan** – Lead Nurse for Adult Safeguarding Coventry & Warwickshire Partnership Trust
- **Andrew Meyer** – Organisational Safeguarding Lead, Orbit Group Ltd
- **Edward Williams** - Operations Manager Adult Social Care Warwickshire County Council
- **Rachel Jackson** –Lead Commissioner – Vulnerable People Warwickshire County Council
- **Rachel Shuter** – Service Manager Refuge
- **Cheryl Bridges** – Community Safety Manager Warwickshire County Council
- **Jonathon Toy** – Group manager Trading Standards and Community Safety WCC
- **Stavroula Sidiropoulou** – Domestic Homicide Review Officer
- **Frances Walsh** Named Professional for Safeguarding SWCCG (now CWCCG)

1.8.2 The Panel members confirmed they had no direct involvement in the case, nor had line management responsibility for any of those involved. The Panel was supported bythe DHR Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur because of this review having been undertaken. The DHR Panel met on the following occasions:

- 14th May 2020 (virtual meeting due to Covid-19),
- 26th June 2020 virtual,
- 28th July 2020 virtual
- 13th August 2020 virtual
- 16th October 2020 virtual
- 10th November 2020 with County Council Legal Representative

1.8.3 On 5th February 2021, the SWCSP approved the final version of the overview report and its recommendations, although there were some amendments to the report further to input from Christian Congregation of Jehovah's Witnesses (CCJW). On 24th May 2022, the report was re-presented to the SWCSP Board and was accepted as being the final version.

1.9 Independent Chair and Author

1.9.1 The Home Office guidance[10] requires that:

[10] Home Office Guidance 2016 page 12
[11] IMRs – Individual Management Reviews from agencies.

"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS[11] and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."

1.9.2 The Independent Author, Mr Malcolm Ross, was appointed at an early stage of this review. He is a former Detective Superintendent with West Midlands Police where he was responsible for around 85 homicide investigations many of them concerning domestic abuse/homicide cases. Since retiring in 1999, he has 23 years' experience in writing over 80 Serious Case Reviews and since 2011, performing both roles of Chair and Author in relation to 60 Domestic Homicide Reviews. Prior to this review he has not been involved either directly or indirectly with members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the Panel, (some of which were virtual meetings due to the Coronavirus),the members of which have contributed to the process of the preparation of the reportand recommendations and have helpfully commented upon it.

1.10 Parallel Proceedings

1.10.1 Warwickshire Police investigated the death of Poppy and submitted a file to HM Senior Coroner. Since the perpetrator died shortly after this event there are no ongoing Criminal proceedings. The circumstances of the death of Dad have been reported to a different Coroner as the hospital where he died lies within a different Senior Coroner's jurisdiction. It is worthy of note that as Dad died whilst technically in custody, Warwickshire Police have referred his death to the Independent Office of Police Conduct, but that does not impact on this review whatsoever.

1.11 Terms of Reference

1.11.1 The Terms of Reference for this review can be found at Appendix No.1 to this report.

1.12. Equality and Diversity/Individual Needs

1.12.1 Home Office Guidance requires consideration of individual needs and specifically:

> 'Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted'

1.12.2 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

1.12.3 The review gave due consideration to all of the Protected Characteristics under the Act.

1.12.4 The Protected Characteristics are: age, disability, gender reassignment, marriage and

civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation. In this case age, disability and religion are significant factors and are relevant to the outcome of the events that lead to Poppy's death, and subsequently to Dad's death.

1.12.5 There was nothing to indicate that there was any discrimination in this case that was contrary to the Act, whilst appreciating that Poppy and Dad had significant medical needs of their own.

1.13 Dissemination

1.13.1 A copy of the report has been circulated to Panel members and the Safer South Warwickshire Community Partnership Board. Copies have also been circulated to HM Senior Coroner Warwickshire and HM Senior Coroner Worcestershire to inform them as they held the inquests into both Poppy and Dad. The report has also been provided to the family at various stages during this review process. In accordance with the recommendations,a copy of the report has been provided to the Charity Commission for their information. A draft report has been provided to Christian Congregation of Jehovah's Witnesses (CCJW), an unincorporated association used by the Britain Branch Office of Jehovah's Witnesses based in Chelmsford. They have responded and their comments are included later in this report.

1.14 Structure of the report

1.14.1 The process of compiling this report has involved obtaining information from agencies, many discussions with the family members, speaking to an elder from the local congregation of Jehovah's Witnesses and also taking into account the views of the report from CCJW. There was also the determination of HM Senior Coroner for Warwickshire to consider.

1.14.2 HM Senior Coroner for Warwickshire determined that a friend and an elder from the local congregation to whom Dad made the comment to that he was thinking of taking Poppy's life acted reasonably when his friend, the elder said that he did not think that the comment was serious and in response read a single scripture from the Bible about dealing with anxiety.

1.14.3 The Panel has sought view from agencies, family and the CCJW which are important to include to ensure a balanced view of the facts and the interpretation of those facts. The report does not wish to blame or conclude any fault just as HM Senior Coroner did not, but the report sets out the facts from all aspects of the review and makes recommendations that hopefully will go some way to preventing deaths in similar circumstances.

1.14.4 In order to simplify the report, it will consist of the various sections as outlined above in order to distinguish between the factual chronology, the Panel's interpretation of those facts with recommendations, the views of the family and the views of CCJW.

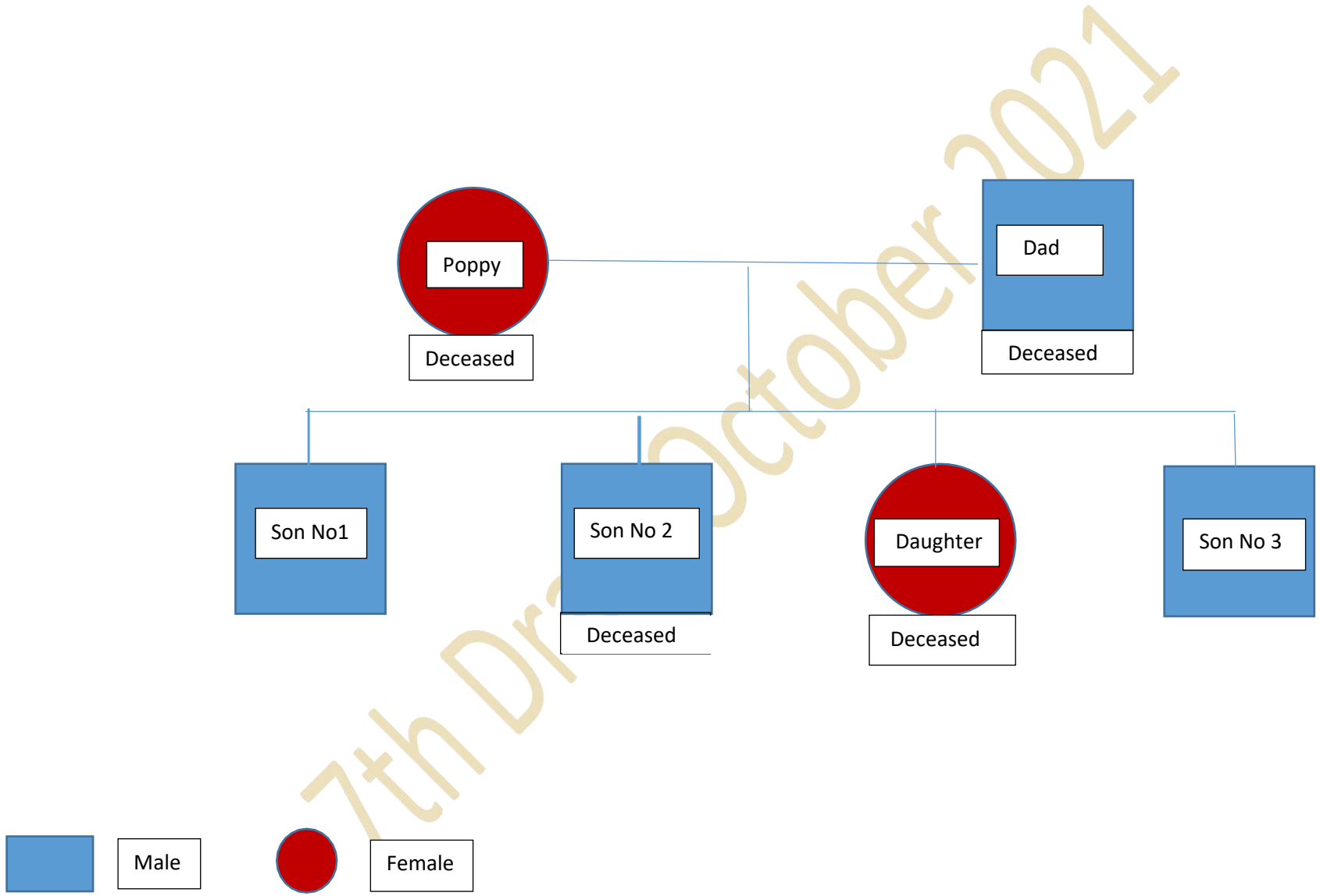
1.15 Subjects of the Review

1.15.1 The following genogram identifies the family members, friends and colleagues in this case, as represented by the following key:

Victim	**Poppy**
Perpetrator	**Dad**
Son No 1	**Did not engage with the review process**
Son No 2	**Deceased**
Son No 3	**Engaged with process**

Daughter	**Deceased**

GENOGRAM



2. Summary

2.1 This Domestic Homicide Review concerns the death of an 80 year old woman, Poppy, who was fatally stabbed by her 82 year old husband, Dad, in their home in Warwickshire in February 2020. They had been married for 61 years and had four children. The second child, a male died at the age of 52 years in unknown circumstances whilst he was in the Far East. The third child, a female, died 5 months after birth leaving two sons, the youngest of which lives with his partner. The oldest son had been estranged from his parents for some time. Both parents were white, British and followed the Jehovah's Witness religion.

2.2 It is known that both Poppy and Dad had medical issues requiring hospital treatments. There is evidence to suggest that Dad was becoming confused and his behaviour was described as him appearing to be muddled. According to the son's understanding, Dad was due to have his second endoscopy appointment on the day he killed his wife. In fact, an appointment was being arranged for a screening test for dementia to take place later,that week, possibly on the Tuesday.

2.3 The motive for the murder is unclear. During interview by the Police whilst he was in custody Dad could describe in detail what had happened. He said Poppy went to sleep in her chair and he went to bed. He woke up in the early hours in the morning, went to the kitchen, he took a knife from the kitchen drawer and used it to stab Poppy multiple times. He told Police that after killing Poppy, he went to bed and later that morning confessed to a friend what he had done.

2.4 Dad was arrested and interviewed by the police. He readily admitted all that he had done but could not explain why he had killed Poppy. He was initially remanded in custody but when his case came before the Crown Court within a few days of his initial Magistrate's Court hearing, he was too ill to attend. The Crown Court Judge ordered that he be transferred to hospital, where sadly, after a short time Dad died of natural causes, which was Inanition, congestive cardiac failure, atrial fibrillation, from lack of adequate nutrition and hydration, due in part to his wilful refusal to accept food and drink provided to him, but also his difficulty in swallowing food. It appears that Poppy had some mobility problems and she would sit all day and sleepall night in a chair in the lounge, because she found that more comfortable than sleeping in a bed.

2.5 Information obtained from the son, who engaged with the review process, appears to indicate that Poppy had ordered a freezer. On delivery it seems that the generic instructions for the freezer were examined by Dad who interpreted the instructions to be for the wrong sort of item. In fact, the freezer was an American make and was called a refrigerator. It seems that he mistook the item to be a fridge and he was upset by this and indicated that he and Poppy had financial problems. He became very confused which was also demonstrated while he was being interviewed by the Police.

2.6 It transpires that the couple were in a healthy financial position albeit that Dad seemed to be convinced that they had money problems.

2.7 There is no suggestion from anyone spoken to through the Police investigation, that there is any evidence of domestic abuse or domestic problems between Poppy and Dad. The neighbour of the couple whose house is attached describes how she could hear either of the couple coughing, the walls being so thin. There were no occasions when she heard arguing between them.

2.8 The other neighbour whose house was not attached to the couple's also indicate that they had no concerns about any domestic disputes. This is confirmed by the son.

2.9 It appears, however, that a friend of Dad's who was an elder at the local congregation (and an ex-policeman), who Dad admitted the offence to, said that a short time before the death of Poppy he was aware that Dad and Poppy had made arrangements for a solicitor to visit them at their home in order to arrange Power of Attorney, and normal wills. This took place over a period over three weeks and was completed by a local solicitor on the Friday before the death which was the following Monday.

2.10 The friend has told the review author, that when the arrangements were being made for the solicitor to visit, Dad had stated that he wished to pay for the services of the solicitor on the day the documents were agreed and signed.

2.11 The solicitor and the friend went to the couple's house on the Friday afternoon and the documents were agreed and signed. The friend said that Dad told the solicitor that he wanted to pay there and then but the solicitor said that it was possibly too late in the day as no-one would be at the office to take payment over the telephone. The solicitor suggested that Dad could call the office on Monday and pay then. Dad got agitated and said that 'Monday would be too late'. The solicitor rang his office and managed to catch a member of staff before they left, and payment was made.

2.12 According to the friend, Dad told him, in the presence and hearing of Poppy, that he thought about taking the life of Poppy by using a knife. The friend thought nothing more of that comment. Poppy did not react to the comment and did not appear to be bothered by it. When asked by the report author what the friend may have thought was behind that comment, the friend said that Dad had told him that both he and Poppy were in their 80's and frustrated.

2.13 HM Senior Coroner for Warwickshire was informed of the death of Poppy and HM Senior Coroner forWorcestershire was informed of the death of Dad, who died in an adjoining Coronial jurisdiction. In March 2021 HM Senior Coroner for Worcestershire held an Inquest into thedeath of Dad and determined that he had died from:

1a. Acute Kidney Injury
1b. Inanition
2. Congestive Cardiac Failure, Atrial Fibrillation, Frailty, Oesophagitis

Conclusion. {Dad] died from lack of adequate nutrition and hydration, due in part to his wilful refusal to accept food and drink provided to him, but also his difficulty in swallowing food.

2.14 On 28th April 2021, HM Senior Coroner for Warwickshire held an Inquest into the death of Poppy. The Senior Coroner heard evidence from the friend of Dad who was an elder within the local congregation of Jehovah's Witnesses, the family members and from the author of this DHR. The Senior Coroner determined that Poppy had been unlawfully killed. At the conclusion of the Inquest HM Senior Coroner made a Regulation 28: Report to Prevent Future Deaths (the Report). At paragraph 5 of the Report HM Senior Coroner detailed that during the course of the inquest it was accepted that CCJW do not have any policy regarding safeguarding of vulnerable adults who are members of the congregation and that the reply from the CCJW is unclear whether they propose to adopt such a policy or not. HM Senior Coroner thus held at paragraph 7 of the Report that CCJW had 56 days to respond to the Report and that the response must contain details of action taken or proposed to be taken, setting out the timetable for action or explain why no action is proposed. The Senior Coroner indicated that he made the Regulation 28 report not because he considered that the absence of a policy made any

difference in this case, but so that CCJW could explain its thinking CCJW replied to HM Senior Coroner that congregations of Jehovah's Witnesses do not carry out any activities that formally bring vulnerable adults into their care. Therefore, it is their understanding that congregations do not fall within the scope of legislation and regulatory guidance concerning those who work with or provide care to vulnerable adults, thus obviating the need for a formal policy. Nonetheless, although not having a legal or regulatory obligation to do so, as made clear in religious guidance published by Jehovah's Witnesses they consider it a Christian duty to do what they reasonably can to provide support to vulnerable adults and their family members. A copy of their response is shown as an appendix to this Overview Report.

2.15 As stated, HM Senior Coroner for Warwickshire determined that dad had unlawfully killed Poppy. Dad died before he was tried by the Crown Court and therefore there has been no judicial proceedings to determine whether Dad had the necessary criminal intent to commit murder or whether his circumstances could have resulted in a conviction for manslaughter. It can only be legally stated that Dad unlawfully killed Poppy.

3. Chronology/Sequence of events.

3.1 Whilst the scoping dates for this review extend from 1st January 2014 to the end of February 2020, which was nearly 2 weeks after the death of Poppy, the vast majority of chronology entries at the beginning of the scoping period refer to almost daily home visits by the District Nurse to treat Poppy's ulcerated legs. Suffice to say that unless there is anything significant at any of these home visits, each individual visit will not be mentioned. What is clear however, is that there was continuity with the same District Nurse treating Poppy for a long period of time and later in the chronology of this case, the same District Nurse treated Dad for a similar complaint. The inference of this continuity is that the District Nurse formed a strong relationship with both Poppy and Dad and that gave ample opportunity for Poppy to disclose any concerns she may have had if there had been any suspicion of abuse or coercive and controlling behaviour from Dad.

3.2 Interspersed with daily District Nurse visits, were numerous hospital appointments for both Poppy and Dad and again there were opportunities for Poppy to disclose to hospital staff any concerning behaviour but there is nothing recorded to show that she did.

3.3 The daily visits, however, indicate that Poppy had continuity of District Nurse and when Dad had the need for his own District Nurse, the same one provided services for both him and Poppy. A good relationship was maintained with the District Nurse.

3.4 During 2018, the chronology mentions several appointments for Poppy at hospital, for either a review of her treatment for her legs or in June 2018, treatment for a Urinary Tract Infection.

3.5 In January 2018, an ambulance was called to the home address. Poppy had fallen as she was moving from her chair to her walking frame and could not get up. The ambulance crew lifted her off the floor, assessed her and found no injury. She was not taken to hospital.

3.6 In February 2019 Poppy had a visit from the District Nurse and had a Waterlow

Assessment[13] which scored 16. It was noted that her mobility was reduced, and she was sleeping in a chair at night. On 18th February 2019, an ambulance was called to Dad who was suffering leg pains, which was thought to be a DVT, (Deep Vein Thrombosis). On examination at hospital a DVT was ruled out and he was discharged home.

3.7 In March 2019, Poppy was seen at the Vascular Clinic at a local hospital and the following day, 10th March 2019, Dad was taken to the A&E by his family due to him being 'off his legs' and feeling unwell. An X-ray showed no injury to his legs and he was referred to an Occupational Therapist.

3.8 On the 11th March 2019 Dad had a telephone consultation with the hospital, and it was noticed that he informed the hospital that his wife uses a stick to walk. There were handrails installed at home but they were not suitable for him and he was falling. Poppy had use of a wheelchair outside, but Dad could not get it into the bathroom. He was able to manage some meals. Poppy was only able to use one arm due to arthritis. He explained that there was no care support at present and his wife was managing to wash his legs and put dressings on his ulcers. He was driving but didn't feel safe and that he had fallen over twice in the last two weeks. He explained how his daughter in law was concerned about how he and Poppy were coping. The daughter-in-law was also expressing concerns that they were both refusing assistance even though there were many GP and hospital visits.

3.9 Sometime before his death, Dad had made an advanced decision not to be resuscitated as he did not want to end up on a life support machine. Dad's son and daughter-in-law took him to one GP's appointment when it was decided that Dad was no longer safe to drive. He was advised not to drive any more. The District Nurse had made a note to say that Dad had multiple pressuressores which ranged from grade 3 to deep tissue injury. This was at the same time thatPoppy was suffering with severely ulcerated legs.

3.10 Both Dad and Poppy followed the Jehovah's Witnesses faith. On the 18th March 2019 there is a note to indicate that Dad, despite his frailty and danger of falling, was still going on the streets preaching the Jehovah's Witnesses' message 3 times a week.

3.11 Daily visits by the District Nurse continued for both Poppy and Dad and it is noted that on 1st May 2019 that he attended for a podiatry appointment where he reported that he was having 'funny spells' where he couldn't stand or walk. It appeared that he was still driving because this was discussed with him.

3.12 The care and treatment to Poppy and Dad's ulcerated legs continued throughout May, June and July 2019. On the 18th July 2019 the District Nurse noted that Poppy was anxious during the change of dressing to her legs, and she was worried that her wounds may get infected with flies. Dad was vexed about the fact that for some reason no dressings had been sent to the house and they had run out. The District Nurse apologised and asked for an urgent delivery to be made. The family paid for special dressings.

[13] Waterlow Assessment Tool -The primary aim of this tool is to assist in assessing the risk of a patient/clientdeveloping a pressure ulcer. The tool identifies three 'at risk' categories, a score of 10-14 indicates 'at risk' ascore of 15-19 indicates 'high risk',

3.13 On the 25th July 2019, the District Nurse visited and found that both of Poppy's feet and toes were infected with maggots. Her feet were cleaned and dressed but the

District Nurse noticed flies around the house. They were advised to buy some fly tape and the nurse was told that they had tried but they couldn't find any. The District Nurse visits were increased. At subsequent visits the District Nurse found no more evidence of maggots and by mid-August both of Poppy's legs appeared to be improving.

3.14 On the 26th August 2019 however, the District Nurse found exudate, a discharge, showing through Poppy's bandages. On the 2nd September 2019 Poppy's feet showed macerated and copious amounts of dry skin. There was concern about another contamination of flies and maggots, and the infestation was found on 6th September 2019.

3.15 On the 8th October 2019, Dad was admitted to A&E at a local hospital following chest pains and he had collapsed. He underwent a CT scan[1] to his head and a chest X-ray. The CT scan showed global age-related changes and the X-ray showed no new concerns.

3.16 The District Nurse visits continued throughout October 2019. In November 2019 Poppy was taken to A&E with a swollen hand but there is nothing to indicate what had caused the swelling. A&E records on the General Practitioner (GP) notes show that her wedding ring was stuck on her finger.

3.17 In January 2020 Dad was taken to hospital for a gastroenterology investigation.

3.18 In February 2020, the District Nurse had a telephone consultation with Poppy to make arrangements to change their dressings that day. The District Nurse was told that there was a solicitor due to visit the couple on the Friday (14th February) and the plan was changed for the District Nurse to attend on Monday and Thursday the following week.

3.19 Later in February 2020 the District Nurse visited. She noted that Dad didn't seem himself that day. He was sitting in the kitchen with his head in his hands. She asked him if he was OK, and he replied that he was fine. The District Nurse asked Poppy about Dad's welfare and Poppy told her that her husband was getting more forgetful, and she thought he was depressed. The District Nurse called the GP, and an appointment was to be made to see Dad the following week.

3.20 On the same day a GP telephoned Dad to organise a follow up blood test. The GP noted that Dad sounded quieter, muddled and appeared to be struggling with his mood. It is also recorded that the District Nurse told the GP that Dad had been stopped from driving.

3.21 Dad had a friend who also was an elder in the local congregation of Jehovah's Witnesses and Dad had known his friend for 6-7 years.

3.22 The friend told the report Author that he had been asked by Dad to help him arrange Power of Attorney, a living will and normal wills for him and Poppy. The friend assisted Dad to prepare a Living Will privately. The friend knew a solicitor and arrangements were made for the solicitor to visit the couple during February 2020 (two visits were made over the course of three weeks) to prepare the Power of Attorney and normal wills. The friend had already spoken to Dad about his wishes regarding the Power of Attorney and on the arrival of the solicitor the necessary paperwork was completed and signed.

3.23 According to the friend, Dad had made it clear that he wanted to pay the solicitor on the day of the visit. When the business with the solicitor had been completed it appeared that it was late on the Friday afternoon and Dad offered to pay the solicitor there and then. The solicitor said it was probably too late to pay on that day as by that

14. CT Scan – Computed Tomography Scan

time the office staff had probably left, and he was advised to ring the office to pay on the following Monday. Dad became agitated and insisted on paying. The solicitor contacted the office and managed to find someone to take Dad's payment. When it was suggested that he could pay on the Monday, according to the friend Dad stated, 'Monday will be too late'.

3.24 It appears that the Saturday and the Sunday passed as usual, but on the Monday when the friend woke, he noticed he'd had several missed calls at 6.48 am and 7.03 am that morning, from Dad. He immediately contacted Dad who told him that he had killed Poppy. The friend immediately went to the home address and found Poppy lifeless in the chair. The emergency services were called. Poppy was pronounced dead at the scene. There were clear and obvious stab wounds seen. Dad was arrested and taken into custody where he was immediately seen by medical professionals and mental health professionals.

3.25 Whilst the police were at the house Dad's son and daughter in law arrived at the scene. They were unaware at that stage that Dad had killed Poppy.

3.26 Whilst in custody extensive medical checks were made on Dad, with a forensic assessment, mental health assessment, an old age psychiatrist consultation and he was also seen by AMHP (Approved Mental Health Practitioner). Dad was deemed fit to be interviewed with an appropriate adult being present and adjustments made to provide frequent rest breaks and shorter questioning sessions.

3.27 Dad made a full and frank admission stating that he got up in the middle of the night, he went to the kitchen, got a knife and stabbed Poppy to death whilst she was in the chair. He expressed concern about Poppy being slow, unable to read or write and taking time to grasp things. (The son will say that Poppy was able to read and write and cannot understand why this would have been said). Dad explained about how he doted on her and how she was important to him, and he thought she was beautiful. He described himself as a well-educated, intelligent man. He was a regular participant of the Jehovah Witness religion. Whilst he made a detailed admission of what he did, he did not explain the motive behind the attack on Poppy.

3.28 Dad was taken from police detention to the local hospital in a confused state complaining of chest pain. He was X-rayed and another CT scan was conducted but nothing was found, and he was taken back to police custody. His detention was extended by the Superintendent of Police. Dad was charged with the murder of Poppy and he appeared before the Magistrates the following day and remanded to the local prison.

3.29 Dad was taken ill at the prison and taken to the local hospital in a confused state with limited speech. Another CT scan showed that he was in the early stages of dementia and a referral was made to the memory clinic. He was discharged back to prison. He was due to appear before the Crown court on that day, but the court was advised he was receiving hospital treatment.

3.30 On the 8th March 2020 Dad was again taken to a local hospital from prison with urinary problems. He was treated with anti-biotics and again discharged back to prison.

3.31 On the 26th March 2020 Dad was taken from prison to hospital with severe renal failure and heart failure. End of Life Pathway was commenced and Do Not Resuscitate and Respect forms were completed.

3.32 In April 2020, Dad died of acute kidney failure, Inanition, Congestive Cardiac failure, Atrial Fibrillation, frailty, Oesophagitis and a lack of adequate nutrition and hydration due to his wilful refusal to accept adequate food and drink provided to him but also his difficulty in swallowing food.

4. Views of family and friends

4.1 The Overview Author has had significant contact with the younger of the two surviving sons. On the advice of this son there has been no contact with the oldest son other than an initial letter of introduction from the Author detailing the DHR process. There has been no response from the oldest son to that letter.

4.2 The son that has engaged has given a detailed description of life as he knew it in the family home with his thoughts about his parents. He first wanted to point out and commend the work done for his parents by the District Nurses and hospital staff. He said he could not praise them enough and described them as being 'brilliant'. He described the sad circumstances of the deaths of his other two siblings and how his older brother had his own personal problems and adopted a lifestyle that was contrary to the views of his parents' faith.

4.3 The son describes the effects that the illness of his mother and his father had on their lives and how the mobility problems of his mother affected his father as he was her carer.

4.4 He described how his father had to stop driving because of several accidents due to the blood supply to his feet causing problems with the sensation in his feet. He said that his father had become very forgetful, and he would be distracted easily and have blank moments. He had problems swallowing and his mother had asked the GP to look at his father's possible dementia problems, but she was told that the GP would deal with his swallowing problems first.

4.5 His mother was diabetic and had been using a wheelchair for 10 years. She suffered froma hiatus hernia and long-term leg ulcers. His mother could not get in or out of bed, so she slept in a chair and despite all of her problems he described his mother as being a very happy person who never complained albeit she was in constant pain. He said all she wanted was a constant supply of tea. The son describes how Poppy was totally dependent upon him and his wife, and also Dad, for nearly everything. The son and daughter-in-law would see Poppy and Dad most days. She had no friends of her own. She could not get out of the house without considerable help from the son and daughter-in-law and she was almost totally immobile. The only people she saw was Dad, the son and daughter-in-law and the District Nurse.

4.6 The son said that his parents were old fashioned and never asked for help from anyone.

4.7 He described the issue around the confusion over the refrigerator/freezer and how that upset his father. It was clear to the son that his parents were struggling to cope in their house and the son and his partner actually made enquiries with their landlords to see if they could get permission for his parents to live with them. Their landlord agreed but both his parents declined the offer. His father wanted to stay close to the Kingdom Hall where the local congregation met for worship.

4.8 The son described how his father would still go knocking doors spreading the word and faith of the Jehovah's Witnesses until his immobility prevented him from doing so.He was aware of the arrangements with the solicitor through his father's friend and he was aware of the outcome of the Power of Attorney arrangements.

4.9 The son and daughter-in-law have been provided with a copy of the Overview report for

them to give their thoughts on its contents. They have also had sight of the letter written from the CCJW, Legal Department which states that on 12th February 2020 two elders from the local congregation shared concerns they had about Dad visited the son on 12th February 2020, to share concerns they had about Dad.

4.10 The Son and daughter-in-law shared with the Overview Author a recording of an answer phone message they had received shortly after the discovery of Poppy's death. It was from Dad's sister, who is a missionary for the Jehovah's Witness faith in Bolivia. The Aunt explained that she had been in contact with the local congregation with which Dad associated and had been told that Dad had told the elder what he had done. The Aunt assumed that Dad had selected this particular elder because the elder had been in the police service and would therefore know what to do.

The Views of the Christian Congregation of Jehovah's Witnesses

4.11 On two occasions the Overview Author had conversations with the friend of Dad who also was an elder in the local congregation of Jehovah's Witnesses.

4.12 Jehovah's Witnesses are members of a Christian based religious movement and it is estimated that there are nearly 7 million Witnesses in 235 countries worldwide. Members of the movement are probably best known for their door to door evangelical work 'witnessing' from house to house, offering Bible literature and evangelizing and converting people to the truth.

4.13 CCJW have provided this review with further detail about their religious based movement and which is set out in paragraphs 4.14-4.16 below.

4.14 A "Congregation of Jehovah's Witnesses" generally comprises individual congregants living in a particular neighbourhood or area. They generally meet in places of worship called Kingdom Halls. They hold two weekly religious services at their Kingdom Halls, each lasting approximately 1 hour and 45 minutes. One service is usually held on a weeknight, with the other service held on the weekend. The instruction is Bible-based, practical, and educational, with opportunities for audience participation. Unlike some other religions, congregations of Jehovah's Witnesses do not carry out any activities that formally bring vulnerable adults into their care. For example, congregations do not operate or sponsor care-homes, day-care centres or any activities that assume responsibility for the care of vulnerable adults.

4.15 An "elder" is a religious minister of Jehovah's Witnesses. A body of elders administers to the spiritual needs of each congregation. Elders carry out a number of religious responsibilities, including presiding over religious services and attending to the spiritual needs of congregants. As spiritual shepherds, they also provide comfort and support to congregants who request pastoral visits. The Scriptural qualifications of elders are set out in the Bible. When a congregant requests spiritual help (referred to as "shepherding"), the body of elders will assign the elders most qualified to offer that help. Elders do not exercise control over the faith of individual Jehovah's Witnesses and, therefore, it is up to individual congregants whether to request or accept pastoral support.

4.16 All elders are expected to take the lead in shepherding, teaching, and evangelizing and are trained to do so. Elders do not receive any payment or remuneration. Thus, they are in no sense employees of any religious corporation. Most are secularly employed or self-employed (or retired) and care for the needs of their own families. They sacrifice time and energy to perform their religious duties voluntarily and free of charge for the congregation, generally in the evenings and weekends. For most elders, the demands of caring for their families means that they can devote only a few hours each week to attending to the needs of the congregation.

4.17 Towards the end of May 2020, the Overview Author spoke to Dad's friend. The friend said he'd known both Dad and Poppy for 6-7 years and they were part of the local congregation. He said Poppy was using a wheelchair and couldnot do a lot for herself. Dad looked after her, fed her and supervised her medication but over the last two years things had been more difficult for them as they were both getting older.

4.18 The friend was aware that Dad had stopped driving of his own accord. He had written his car off on one occasion and had crashed into a wall at home. The GP notes state that Dad had been stopped from driving and the GP had been requested by the DVLA to complete a fitness to drive certificate on 21st October 2019, as a result of an accident that Dad had in his car.

4.19 The friend described how Dad had asked him for some help arranging a Power of Attorney through a solicitor and the sequence of events as described earlier in this report were confirmed by the friend. On having sight of this DHR the friend wished it to be made clear that he helped Dad and Poppy regarding their personal financial/legal matters (preparing a living will and assisting with Power of Attorney and wills) as a friend as he had done with other friends. He said he did not assist Dad and Poppy in this way as a representative of the local congregation or in connection with any of his religious responsibilities as an elder. He understood that Dad wanted him to assist with their personal matters because Dad knew that he previously worked as a police officer and had a number of contacts in the local community. The friend said that as an elder he did not have any role or congregation assignment in relation to the personal financial affairs of congregants, his role is, primarily, to take the lead together with his fellow elders in conducting weekly religious services and providing spiritual assistance to congregants. The friend also said that if he had been asked by his fellow elders to provide spiritual assistance to Dad and Poppy (in the form of a pastoral visit to their home) he would have attended with another elder and a specific appointment would have been arranged (which are known as 'shepherding visits'). The friend said he was not involved in any shepherding visits with Dad and Poppy.

4.20 The friend described Dad as a very clever, intelligent man and very sharp. Dad had been an engineer when he worked for the NHS and he was a Union rep so things 'had to be right'.

4.21 Regarding the relationship between Dad and Poppy he said he never saw anything that made him worried or suspicious but then disclosed something that had been worrying him. He described how Dad, three days before the murder of Poppy, told the friend that he had been thinking of 'ending it all for them both'. He had been 'thinking about taking his and Poppy's life. He said that he never thought anything more about that other than it was a strange comment to make and that Dad was in his 80's, frustratedand had a heart condition.

4.22 The friend was spoken to again by the Author in May 2020 and specifically asked about his thoughts regarding Dad's comment to the solicitor that 'Monday would be too late'. About that, the friend said that he thought it was typical of Dad who didn't like to owe anybody money. However, the friend has subsequently advised that he has no recollection of saying that [Dad] 'didn't like to owe anybody money', although the Report Author made a contemporaneous note of the conversation with the friend.

4.23 The friend was specifically asked about his views regarding comments that Dad made about ending his and Poppy's life. The friend responded by saying that Dad had made those comments in the middle of an hour long conversation about how low he felt due to his medical conditions. He said that Poppy was present, she heard the comment and laughed it off.

4.24 The Report Author recorded that the friend added that when Dad made these

comments that he had quoted scriptures from the Bible to Dad about the principles about right and wrong, life being precious, thinking of life and not death and that he shouldn't be talking or thinking like that. However, the friend has subsequently stated that he shared with Dad a single verse from the Bible about dealing with anxiety, which is supported by the statement the friend made to the police. He felt this was appropriate as he said neither he nor Poppy viewed the comment as serious. The friend felt that Dad just needed some comfort and encouragement aboutthe general anxiety he was feeling. He thought that Dad was trying to illustrate his feelings and that he did not take it that he meant any malice. (It is not known how the friend knew that Poppy viewed the comment as not being serious). When asked what would the friend have done if he had detected malice in the comments, the friend said that if he had viewed what he regarded as a throw away, isolated commentas a credible threat to Poppy he would have reported the matter to the Police or Social Services immediately. The friend said that he put the comments down to Dad's frustration and the fact he was struggling and he, the friend, had pointed out to Dad thatlife was precious.

4.25 The Author asked the friend about the safeguarding policies within the Jehovah Witness religion. The friend explained that he was not aware of a written policy in relation to adult safeguarding.

4.26 The Author asked as an elder of the local congregation, did he have any duty of care towards his congregation, to which the friend said he definitely did have a duty of care. The friend has subsequently indicated to HM Senior Coroner, that when he said this he did not mean as a legal or secular duty but that he meant that his Bible trained consciencemoved him to show love to all of his brothers and sisters in the faith (and indeed everyone he comes into contact with) where he is able to lend a hand.

4.27 The friend said that he is part of a Body of elders who look after their brothers and give advice about anything, make sure they are safe etc. He added 'Elders go beyond what the Bible says', which he subsequently explained means he applies the principles in the Bible in areas of life which may not be specifically covered by the Bible.

4.28 HM Senior Coroner for Warwickshire held an Inquest touching into the death of Poppy. The friend set out in his witness statement for those proceedings that regardless of whetheror not Jehovah's Witnesses have a policy concerning domestic abuse, he would not have done anything different in this case in response to Dad's comment. He said it wasan out of character, throw-away remark that he made in front of his wife Poppy. He said that it was said in a way that he understood was not meant to be taken seriously and that Poppy was not at all bothered by the comment and that in all the years that he had known Dad he had never once said or done anything to make him think he was a threat to Poppy or anyone.

4.29 Having heard evidence during the Inquest proceedings the Senior Coroner set out that he wassatisfied that the friend had acted reasonably and that it was reasonable for him to have considered the remark made by Dad as not a serious one but a remark made out of frustration.

5. Analysis and recommendations.

5.1 This Review deals with the unlawful killing of an elderly wife, Poppy by her elderly husband, Dad, in tragic and unexpected circumstances. Both of them had significant health and mobility issues and both had considerable input from services, especially health services. Dad used walking aids to help his mobility. Adult Social Care had limited connection with the couple dating back to 2012 when an Occupational Therapy Assessment indicated that Poppy required 'substantial needs' under Fair Access to

Care Services (FACS) criteria. The assessment recommended that their housing providers, Orbit provide an adaptation of their existing bathroom to a level access shower and to provide a bed rail. That was completed by Orbit in January 2014, but by March 2019, there had been a change of circumstances since 2014 and conditions had not been re-assessed.

5.2 In 2015, Adult Social Care received a request for Reablement Services for Poppy to enable her to regain previous levels of independence following her hospital admission for acute cellulitis. That service lasted for 2 months.

5.3 The Adult Social Care IMR indicates that although both Poppy and Dad had various health needs that impacted on mobility and they both provided support to each other, Poppy was assessed as having a higher level of needs under the FACS criteria in October 2015. The report concludes that the Adult Social Care involvement for both of them was relativelyminor and the assessment and intervention were non-complex in nature. The IMR concludes:

> 'They seemed to maintain good levels of independence and needed only very minimal formal support from outside agencies, although they appeared very willing and open to requesting & receiving support when they needed. There is no indication that the support they provided to each other placed any particular strain on the relationship or impacted either of their wellbeing in any way. Throughout the records, there is every indication that the relationship between [them] was mutually supportive, and there is no evidence of any level of conflict or tension between them. There is no indication in the records that would point towards the possibility of domestic abuse or risk of harm within the relationship.'

The assessment was not revisited as there was no indication of concern.

5.4 For their part the Orbit (housing) IMR indicates that the couple managed their tenancy in a positive way, maintained their rent account in credit and there were no reports of any issues with other residents or to Orbit personnel. Orbit's involvement was limited to work around the bathroom and repairs to windows, roof and soffits.

5.5 Worcestershire Acute Hospital NHS Trust had dealings with both Poppy and Dad individually as outlined in this report. The Trust has submitted an IMR for both and both reports indicated that the services received by each of the couple were as expected and complied with the Trust's policies and practice. There were no indications to the professionals involved that either Dad or Poppy made any disclosures regarding any domestic abuse between the couple. The Trust makes no formal recommendations but identifies 6 areas of good practice that are in existence:

- Worcestershire Acute Hospitals NHS Trust has in place a Hospital Independent Domestic Violence Advisor (IDVA) service.
- Domestic violence/abuse is included within all levels of mandatory training for both adults and children at all levels
- The Trust has an alert (flagging system) in place for Police logs and victims and children of high-risk domestic abuse taken via the Multi Agency Risk Assessment Conference (MARAC).
- The Trust has hosted events with a specific focus on 'asking the question' and signs to look for in relation to domestic violence/abuse – including elder abuse and SafeLives information
- The Trust has available covert items - lip balms, tissues, tampon vouchers containing the number for West Mercia Women's Aid (which also includes a service for male victims)
- The Trust has available a Professionals pack to support staff which contains a wealth of information.

5.6 Coventry and Warwickshire Partnership Trust only had contact with Dad after the death of Poppy and when he was in custody. During an assessment Dad described how he felt unwell, depressed and that his memory was deteriorating – he was unable to remember readings from the Bible which had stopped him preaching the Jehovah's Witnesses religion. He told the assessor that he doted on his wife and loved her, and he thought she was beautiful, although she was slow, unable to read or write and it took her time to grasp things. (The son refutes this comment). Dad spoke about Armageddon being near, which is a belief of the Jehovah's Witnesses religion. Dad reported that he did not have much support at home although he denied ever being threatened or abused. He did, however mention, that he suffered childhood trauma by his father, but did not elaborate on that.

5.7 During the assessment Dad likened his stress as building up and then going "pop". He reported that he would feel more irritable and begin 'ranting and raving'. He reported that he had wanted to kill himself and others. He reported feeling worried about his financial situation and feeling more wound up over the last two to three months. He stated that he did not show emotions but that they gradually built up inside him. He reported being "calm now as the pressure has gone by "doing what I did". When asked if he had any thoughts to harm himself or others he said "my wife" but then stated that she was dead. He reported increased thoughts to harm his wife, when asked if he had planned to harm his wife he stated that he had had thoughts but no plans, he stated that it just felt like a split second decision as he felt he had been pushed past his physical capacity. He stated that his religious beliefs had stopped him from killing himself and his wife earlier until he had just snapped.

5.8 The Coventry and Warwickshire Partnership Trust concludes the report with:

> 'If [Dad] had disclosed the above information to CWPT services prior to his arrest, the pathway set out in the CWPT Domestic Abuse (Clinical) Policy would have been triggered. The policy requires the following response to any disclosure of abuse by a perpetrator:
>
> "*Any client who discloses that they are the perpetrator of domestic abuse should be signposted to specialist domestic abuse perpetrator services and consideration given to risk to the victim and any children. If the identified victim is known to the service a DASH[15] should be completed with the victim if possible*."
>
> As [Dad] was already in custody at the time of his disclosures, this pathway was not triggered.

5.9 There are no formal recommendations made by CWPT other than to review the overall learning and recommendations of this DHR.

5.10 South Warwickshire NHS Foundation Trust provided the significant District Nursing support for both Poppy and Dad and their IMR illustrates how both had capacity to make decisions. There were occasions however, when Poppy declined to take advice around sleeping in a chair rather than a bed and issues around her being a diabetic. On these occasions a Guidance for Non-Concordance Retreatment form was completed in line with policy as set out in SWFT Pressure and Ulcer Prevention and Assessment and Management 2016.

5.11 During the visits to the couple the District Nurse was able to provide insight into the couples' personality and behaviour. The District Nurse saw Dad as a very independent person who relied on his car to take him and Poppy to their medical appointments. He saw his role as looking after Poppy. He found it degrading to ask for help.

5.12 Poppy had clearly stated to the District Nurse that she was the carer for Dad and it is noted that as the health of both of them deteriorated there was some confusion about their perception of each of their roles towards each other.

5.13 It was clear to the IMR Author that Dad and Poppy were known by the District Nurse team extremely well and that they were offered appropriate nursing care. All the District Nurse team were saddened by the outcome of this case.

15 DASH – Domestic Abuse Risk Assessment

5.13 After reviewing the documentation, South Warwickshire NHS Foundation Trust have made three formal recommendations for their Trust.

- To work in conjunction with the Clinical Audit Department to assess the quality of the electronic record keeping. This will be carried out by enquiring what record keeping audits are in place and how they may include quality and analysis of note keeping.
- To work with Operational Managers within District Nurse Services and Podiatry and the training department to offer Domestic Abuse and DASH Safeguarding Training appropriate for their role in adherence with Adult Safeguarding Roles and Competencies for Health Care Staff 2018. This will be part of the training for all health professionals within the Trust.
- To write a multi-agency training package across the Health Economy to consider Older Adult Domestic Abuse.

5.14 The input of the South Warwickshire Clinical Commissioning Group (CCG) on behalf of Primary Care is outlined in the Sequence of Events section of this report. The CCG IMR indicates that the surgery had regular contact with both parties due to their multiple medical conditions. All staff at the practice knew the couple well and Dad's GP described him as being 'quirky'. No one in the surgery felt that they could have predicted what had happened. The IMR stresses that both parties had been seen at home, in the surgery, alone and together where they had ample opportunity to disclose any concerns that they had. The IMR points out, however, that whilst there was no indicator of domestic abuse there is no documentary evidence that the question was ever directly asked by the GP. It also points out that the surgery is an IRIS accredited practice and had any disclosure of that nature been made, staff at the surgery would have been well prepared to act in accordance with the IRIS Pathways.

5.15 Warwickshire Police IMR deals mainly with the events after the initial call to the household when Poppy was found dead in her family home. The Police were not involved with the family prior to those events. A summary of the Police action after Dad was arrested is contained in the Sequence of Events in this report.

5.16 The Police IMR goes on to indicate that neither Dad nor Poppy were subject of MARAC and Dad was not being managed under MAPPA[16]. There were no referrals to the Police in relation to domestic abuse and neither of them considered themselves a victim.

5.17 The Police IMR points out that there are stringent policies in place to deal with any allegations of domestic abuse and DASH risk assessments are commonplace with officers attending incidents of domestic abuse. Warwickshire Police also have dedicated domestic abuse units with domestic abuse risk officers who manage the risk to victims of domestic abuse where the risk is assessed as high. It is the Police IMR Author's opinion that Warwickshire Police are adequately equipped to deal with any incident of domestic abuse reported to them.

5.18 None of the agencies had any indication whatsoever that there were any difficulties between Dad and Poppy. As a warning, Safer Later Lives[17] states:

> 'As a consequence of so few older victims accessing domestic abuse services, professionals tend to believe that domestic abuse does not occur amongst older people. …….. These assumptions may encourage health professionals to link injuries, confusion or depression to age related concerns rather than domestic abuse.

5.19 There were a number of agencies that had regular contact with Poppy and Dad. It is important that each agency is confident that such contacts are viewed as an opportunity to apply the best practice of "routine enquiry" into the possibilities of domestic abuse. Safer Warwickshire Partnership Domestic Violence Strategic Review[18] embeds Routine Enquiry across partner agencies with the recommendation:

> 'Ensure routine enquiry into DA history is built into standard practice within public sector and publicly funded organisations, with clear referral pathways into support services identified and utilised'

5.20 This review makes a similar recommendation to particular agencies:

Recommendation No 1

Coventry and Warwickshire Clinical Commissioning Group, Coventry and Warwickshire Partnership Trust and South Warwickshire NHS Foundation Trust assure the Safer South Warwickshire Community Safety Partnership that the recommendation of the SWP DV Strategic Review, i.e. that Routine Enquiry into Domestic Abuse is embedded into training, policy and procedure.

Christian Congregation of Jehovah's Witnesses

5.22. There is one area of this report that does indicate, in retrospect, that concerns may have been raised if a structured safeguarding policy had been in place. This relates to conversations that Dad had with his friend from the local congregation. In particular it

[16] MAPPA – Multi Agency Public Protection Arrangement

[17] Safer Later Lives: Older People and Domestic Abuse Sage Lives October 2016

[18] Safer Warwickshire Partnership Domestic Violence Strategic Review 2020 Joanne Sharpen AVA(Against Violence and Abuse)

relates to a comment that Dad made to his friend that he had thought of killing himself and Poppy. His friend thinking it was a passing comment and being also an elder from the local congregation dealt with it by quoting a single verse from the Bible about anxiety. The Panel recognises though that the Senior Coroner found the friend's thoughts and actions were reasonable and would not have been any different if there was a policy in place.

5.23 From the conversation the Author had with the friend, it is clear some thought should be given by the charitable organisations that incorporate the Jehovah's Witnesses' faith as to whether they need to implement a structured written safeguarding adult policy and to implement training on its application among the elders of the local congregation.

5.24 With that in mind, the Overview Author spoke by telephone to two representatives of CCJW. It is understood that one was from the Public Information Section and the other

was an In House Solicitor. The brief circumstances of this case and the concerns raised were explained and a request that the Overview Author and a member of the DHR Panel could visit CCJW to discuss the issues. The representative from the Public Information Section said that was not possible due to the Covid-19 pandemic. A further request was made to arrange a virtual zoom meeting and the Overview Author was told to email the full circumstances and they would look into the matter raised. The representative from the Public Information Section said that he would put the proposal of a video conference to the directors and, in order to assist CCJW to respond, he asked the Overview Author to put his specific concerns/questions in writing. The Overview Author subsequently did so on 8 September 2020. CCJW provided a substantive written response on 8 October 2020.

5.25 The Overview Author went on to try to discuss the issue around the possible duty of care of the Elder, who was a Minister of the local congregation and Trustee of the congregation charity, in this case and highlighted the fact that a registered charity such as this specific local congregation in this case, was required to comply with the Charity Commission guidance[19] [20] thus requiring the charity to consider whether it required a structured Safeguarding Policy for Adults and indeed children.

5.26 On having sight of this Overview Report CCJW have indicated that, on the issue of the need for a structured adults safeguarding policy, the In House Solicitor said that:

> "Need to be careful not to conflate what is legally required and what one may choose to do out of moral or religious feeling or responsibility. Care Act and Safeguarding Vulnerable Groups Act (where vulnerable adults legally defined) does not apply to the religious activity of Jehovah's Witnesses as the scope of congregation activity does not extend to care of, or regulated activity with, such groups. As a religion Jehovah's Witnesses do publish much literature for the benefit of adherents to the wider public on how ones can take reasonable steps to protect for example their mental health etc. but that this is distinct from a legal duty to have a policy to take certain steps- not aware of any such legal requirement".

[19] Safeguarding and protecting people for charities and trustees Gov. UK Charities Commission 2017 (https://www.gov.uk/topic/running-charity/staff-volunteers)

[20] Strategy for dealing with safeguarding issues in charities Gov. UK Charities Commission 2017 (https//www.gov.uk/government.publications/strategy-for-dealing-with-safeguarding-issies-in charities)

5.27 The Overview Author received a letter by email from CCJW, Legal Department.The Review Author asked for clarification as to the identity of the author of the letter and it was confirmed that it was sent by an In House Solicitor for CCJW. (Both letter and confirmation are shown at appendix 2 and 3). The letter indicated that they had conducted their own enquiries into the actions of the elder and could find nothing he had done wrong. They explained, "congregations of Jehovah's Witnesses do not arrange or supervise any activity which involves providing personal care for elderly or vulnerable persons. Congregations of Jehovah's Witnesses provide spiritual support and guidance for congregants and the wider community. Two religious services are held each week, at which congregants meet together (currently by zoom) to worship and learn about the Bible. Congregants come from a diverse demographic and include families with young children, single men and women, married couples, as well as elderly individuals. …Individual congregants may assist elderly congregants with routine tasks, for example, help with shopping, cleaning, transport to congregation

meetings. However, this would be a personal arrangement and not a congregation service or activity". It stated that the elder was acting on his own when visiting Dad and not on behalf of the local congregation: "It is important to note that the elders of the Congregation did not arrange or approve for [name of Elder] to provide this personal assistance. Elders of Jehovah's Witnesses are religious ministers and as such provide spiritual assistance to congregants. As elders they do not get involved in congregants' personal, financial matters. If an elder personally decides to assist a congregant or others with such matters, he does so in his personal capacity, and not in connection with any congregation activity or responsibilities as an elder." It went on to say that they had examined the Care Act of 2014 and could find noreference to the Jehovah's Witnesses practices or activities.

5.28 In Safer Later Lives,[21] it states:

> 'The current lack of training on the specific issues faced by older victims of domestic abuse may mean that practitioners lack the skills and knowledge to respond to it confidently'.

5.29 It appears that the local congregation near to where Dad and Poppy lived was a registered charity. It has a charity number on its website and therefore, needs to adhere to the Charity Commission's governance guidance and structure and consider whether the scope of their activities require them to have a structured safeguarding policy for safeguarding children or adults at risk.

5.30 For any charitable organisation this is governed through the Charity Commission and the National Council for Voluntary Organisations who state that all voluntary organisations that work with the general public need to be aware of their safeguarding responsibilities under the law.

5.31 The Charity Commission's safeguarding guidance sets out the specific responsibilities for voluntary organisations, confirming that even if a charity is unregistered, it is expected to follow the guidance and treat safeguarding children and adults at risk as a priority.

[21] Safer Later Lives: Older People and Domestic Abuse Sage Lives October 2016

5.32 The guidance regarding safeguarding adults at risk states:

> "Safeguarding adults at risk means protecting their right to live in safety and free from abuse and neglect. The charity may have trustees, staff, volunteers, beneficiaries, or other connections who are classed as adults at risk.
>
> Safeguarding duties for adults at risk apply to any charity working with anyone aged 18 or over who:
>
> - has needs for care and support (whether or not the local authority is meeting any of those needs) and
> - is experiencing, or is at risk of, abuse or neglect
> - as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

An adult at risk of abuse may:

- have an illness affecting their mental or physical health
- have a learning disability
- suffer from drug or alcohol problems
- be frail

If the charity is in England follow guidance on the Care Act 2014"

5.33 How a charity meets its safeguarding duty should be related to the size and scale of the organisation, what it does and who it works with. The more it works with groups who are at risk and protected in law, the more detailed and thorough the plans must be. This is often referred to as proportionality in safeguarding.

5.34 Charity Commission's guidance for trustees states

> "Protecting people and safeguarding responsibilities should be a governance priority for all charities..... As part of fulfilling your trustee duties, you must take reasonable steps to protect from harm people who come into contact with your charity. This includes people who benefit from your charity's work". 22 Oct 2019.

5.35 In view of the local congregation with which Poppy and Dad were associated not having an safeguarding adult policy, it is considered that having such policies could equip members of these organisations with the knowledge and ability to recognise and report safeguarding concerns to the appropriate statutory authorities.

5.36 This lack of policy seemingly being apparent in the charitable organisations that concern themselves with the Jehovah's Witnesses' faith generally and indeed any other faith based organisations in Warwickshire, the following best practice advice is made:

Best practice advice

The charitable organisations of faith based groups operating in Warwickshire (locally or nationally) should ensure a structured policy on adults' abuse and neglect is written which should include reference on how to respond to concerns of abuse or neglect of older people and adults at risk of domestic abuse, and how to respond to the abuse or neglect of adults with care and support needs. The policy should be embedded into training for Elders, Ministers and Trustees of faith based groups to recognise the signs and be aware of the referral process to statutory agencies.

Recommendation No 2

Warwickshire Safeguarding Adults' Board to consider a means and seek assurance from other Warwickshire faith based groups that they have written structured Safeguarding Policies.

5.37 At the conclusion of the Inquest touching into the death of Poppy on 28 April 2021, HM Senior Coroner for Warwickshire made a Regulation 28: Report to Prevent Future Deaths under paragraph 7, Schedule 5, of the Senior Coroners and Justice Act 2009 and regulations 28 and 29 of the Senior Coroners (Investigations) Regulations 2013. The Senior Coroner made it clear that he was making the Regulation 28 report, not because he considered that the absence of a policy made any difference in this case, but so that CCJW could explain its thinking. That Report was addressed to CCJW and

set out that during the course of the inquest it was accepted that the CCJW do not have any policy regarding safeguarding of vulnerable adults who are members of the congregation and that the issue of such a policy was raised by the author of the Domestic Homicide Review into Poppy's death with the CCJW in October 2020. The Report set out that the reply from the CCJW was unclear whether they propose to adopt such a policy or not. HM Senior Coroner for Warwickshire held that action should be taken to avoid future deaths and that the CCJW have the power to take such action. It is noted by the Panel that when issuing the Regulation 28 report, the Senior Coroner highlighted the very low legal threshold required under Regulation 28 that obliged him to issue a Prevention of Future Deaths Report and that he highlighted that issuing a report was irrespective of the fact that an adult safeguarding policy would not have made a difference in this case. The CCJW have responded to that Report and a copy of that response can be seen at Appendix 5.

5.38 A more global adult abuse policy for the charitable organisations that concern themselves with the Jehovah's Witnesses' faith and indeed any other faith based groups in Warwickshire, would offer structure and guidance on how to respond to abuse/neglect concerns that affect adults, how to address domestic abuse issues and then how to address those concerns should the adult have needs for care and support such as reporting concerns to Adult Social Care or other statutory agencies.

5.39 The SSWCSP, noting that the charitable organisations that concern themselves with the Jehovah's Witness faith do not appear to have a safeguarding policy should consider whether the scope of their activities requires them to have a policy and make a further recommendation to assure itself that other faith based charities within Warwickshire are complying with the Commission's requirements.

5.40 The Overview Author has made a referral to the Charity Commission regarding the circumstances outlined in this review.

Recommendation No 3

South Warwickshire Community Safety Partnership Board ensures that the Charity Commission be provided with a copy of this Domestic Homicide Review.

6. Conclusions

6.1 This DHR concerns the death of an elderly lady by her elderly husband. Both had significant medical needs which were being catered for by a professional team of District Nurses. As and when required both Poppy and Dad had hospital appointments. On each contact they were dealt with in a professional manner within due bounds of agency guidance, policies and procedures. There was very little involvement from Adult Social Care as most of their needs were medical. The housing association, Orbit, did what they could for them in terms of a bathroom conversion and repairs. There was no other agency involvement.

6.2 The recommendations to the charitable organisations that concern themselves with the Jehovah's Witnesses' faith are made with the intention of highlighting the lack of policy and procedures to safeguard adults.

6.3 The motive behind the death of Poppy will never be known. Whilst Dad admitted the actual killing, he gave no insight as to the motive.

6.4 The Panel offer sincere condolences to Poppy and Dad's family. Special appreciation goes to the son and his partner who have been extremely helpful during the process

of this review and without their assistance this review would have been much more difficult.

Overview Report Recommendations

Recommendation No 1 **Page 27**

Coventry and Warwickshire Clinical Commissioning Group, Coventry and Warwickshire Partnership Trust and South Warwickshire NHS Foundation Trust assure the Safer South Warwickshire Community Safety Partnership that the recommendation of the SWP DV Strategic Review, i.e. that Routine Enquiry into Domestic Abuse is embedded into training, policy and procedure.

Best practice advice **Page 30**

The charitable organisations of faith based groups operating in Warwickshire (locally or nationally) should ensure a structured policy on adults' abuse and neglect is written which should include reference on how to respond to concerns of abuse or neglect of

older people and adults at risk of domestic abuse, and how to respond to the abuse or neglect of adults with care and support needs. The policy should be embedded into training for elders, Ministers and Trustees of faith based groups to recognise the signs and be aware of the referral process to statutory agencies.

Recommendation No 2 **Page 30**

Warwickshire Safeguarding Adults' Board to consider a means and seek assurance from other Warwickshire faith based groups that they have written structured Safeguarding Policies.

Recommendation No 3 **Page 31**

South Warwickshire Community Safety Partnership Board ensures that the Charity Commission be provided with a copy of this Domestic Homicide Review.

Single Agency Recommendations

South Warwickshire NHS Foundation Trust

1. To work in conjunction with the clinical audit department to assess the quality of the electronic record keeping. This will be carried out by enquiring what Record Keeping audits are in place and how they may include quality and analysis of note keeping.

2. To work with Operational Managers within DN services and Podiatry and the training department to offer Domestic Abuse and DASH safeguarding training appropriate for their role in adherence with Adult Safeguarding Roles and Competencies for Healthcare Staff, 2018. This will be as part of the training for all health professionals within the Trust.

3. To write a Multi-agency training package across the Health Economy to consider Older Adult Domestic Abuse.

Bibliography

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.

Safer Later Lives: Older People and Domestic Abuse Save Lives October 2016

Invisible Chains. Overcoming Coercive Control in Your Intimate Relationship Lisa Aronson Fontes 2015

Safer Warwickshire Partnership Domestic Violence Strategic Review 2020 Joanne Sharpen AVA (Against Violence and Abuse)

Charity Commission Guidance October 2019

Care Act 2014 – Care and Support Statutory Guidance June 2020

Appendix No 1

TERMS OF REFERENCE

1. Supporting Framework

1.1. The Domestic Homicide Review (DHR) is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

1.2. In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by

A person to whom he was related or with whom he was or had been in an intimate relationship; or

A member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.3. Where the definition, set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

2. Purpose of the DHR

2.1. 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;

2.2. 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;

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

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

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

2.6. Highlight good practice.

3. Methodology

3.1. This DHR will primarily use an investigative, systems focus and Individual Management Review (IMR) approach. This will ensure a full analysis by the IMR author to show comprehensive overview and alignment of actions.

3.2. This will ensure that practical and meaningful engagement of key frontline staff and managers will be carried out by the IMR author on a more experiential basis than solely being asked to respond to written conclusions or recommendations.

3.3. This is more likely to embed learning into practice and support cultural change where required.

4. Scope of the DHR

4.1. Victim: Poppy

4.2. Perpetrator: Dad

Timeframe

4.3 The period of this review will be from 1st January 2014 (the date that the health of both Poppy and Dad started to deteriorate) to the end February 2020, (nearly 2 weeks after the death of Poppy).

4.4 In addition, agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of this adult and include information around wider practice at the time of the incident as well as the practice in the case.

4.5 The Terms of Reference will be a standing item on the agenda of every Panel meeting in order the we can remain flexible in our approach to identify learning opportunities.

5 Agency Reports

5.4 Agency Individual Management Reports will be commissioned from:

- Warwickshire Police
- Warwickshire CCG
- Coventry and Warwick Partnership Trust

Other reports for those agencies having limited contact with the Victim and Perpetrator:

- Housing (Orbit Housing)
- Adult Social Care

5.5 Agencies will be expected to complete a chronology and IMR. Template and guidance attached.

5.6 Any references to the adults, their family or individual members of staff must be in full and later redacted before submission to the Home Office or published.

5.7 Any reasons for non-cooperation must be reported and explained.

5.8 All agency reports must be quality assured and signed off by a senior manager within the agency prior to submission.

5.9 It is requested that any additional information requested from agencies by the DHR Independent Author is submitted on an updated version of the original IMR in red text and dated.

5.10 It is requested that timescales are strictly adhered to and it should be noted that failure to do so may have a direct impact on the content of the DHR and may be referred to in the final Overview Report to the Home Office

5.11 Agencies will be asked to update on any actions identified in the IMR prior to completion of the DHR which will be fed into the final report. Updates will then be requested until all actions are completed.

6 Areas for consideration

Victim:

6.4 Was the victim recognised or considered to be a victim of abuse and did the victim recognise themselves as being an object of abuse?

6.5 Did the victim disclose to anyone and if so, was the response appropriate?

6.6 Was this information recorded and shared where appropriate?

6.7 Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of the victim and their family?

6.8 When, and in what way, were the victim's wishes and feelings ascertained and considered?

6.9 Is it reasonable to assume that the wishes of the victim should have been known?

6.10 Was the victim informed of options/choices to make informed decisions?

6.11 Were they signposted to other agencies?

6.12 Was consideration of vulnerability or disability made by professionals in respect of the victim and perpetrator?

6.13 How accessible were the services for the victim and the perpetrator?

6.14 Was the victim or perpetrator subject to a Multi-agency Risk Assessment Conference (MARAC) or any other multiagency forum?

6.15 Did the victim have any contact with a domestic abuse organisation, charity or helpline?

Perpetrator:

6.16 Was the perpetrator recognised or considered to be a victim of abuse and did the perpetrator recognise themselves as being a perpetrator of abuse?

6.17 Did the perpetrator disclose to anyone, and if so, was the response appropriate?

6.18 Was this information recorded and shared where appropriate?

6.19 Was anything known about the perpetrator? For example, were they being managed under MAPPA, did they require services, did they have access to services.

6.20 Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of the victim and their family?

6.21 Were services accessible for the perpetrator? And were they signposted to services?

6.22 Was consideration of vulnerability or disability made by professionals in respect of the perpetrator?

6.23 Did the perpetrator have contact with any domestic abuse organisation, charity or helpline?

Practitioners:

6.24 Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?

6.25 Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Policy and Procedure:

6.26 Did the agency have policies and procedures in place for dealing with concerns about safeguarding and domestic abuse?

6.27 Did the agency have policy and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (e.g. DASH) and were those assessments correctly used in the case of this victim/perpetrator?

6.28 Where these assessment tools, procedures and policies professionals accepted as being effective?

7 Engagement with the individual/family

7.4 While the primary purpose of the DHR is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in, and across, agencies and services, it is imperative that the views of the individual/family and details of their involvement with the DHR are included in this.

7.5 South Warwickshire Community Safety Partnership, through the Independent Chair, are responsible for informing the family that a DHR has been commissioned and an Independent Chair has been appointed. The DHR process means that agency records will be reviewed and reported upon, this includes medical records of both the victim and perpetrator if consent is agreed by the Perpetrator.

7.6 Firstly, this is in recognition of the impact of the death of the victim giving family members the opportunity to meet the Review Panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process focus on the victim's and perpetrator's perspectives rather than just agency views.

7.7 All IMRs are to include details of any family engagement that has taken place, or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the DHR in addition to the Police Family Liaison Officer, FLO, in respect of criminal proceedings.

8 Media Reporting

8.4 In the event of media interest, all agencies are to use a statement approved and provided by South Warwickshire Community Safety Partnership.

9 Publishing

9.4 It should be noted by all agencies that the DHR Overview Report will be published once completed, unless it would adversely impact on the adult or the family. Publication cannot take place without the permission of the DHR Home Office Quality Assurance Panel.

9.5 The media strategy around publishing will be managed by the DHR Panel in consultation with the chair of South Warwickshire Community Safety Partnership and communicated to all relevant parties as appropriate.

9.6 Consideration should be given by all agencies involved in regards to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware, in advance, of the intended publishing date.

9.7 Whenever appropriate an 'Easy Read' version of the report will be published.

10 Administration

10.4 It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via secure email account (GCSX) or through the Local Authority's Secure Communication System (SCS). Failure to do so will result in a data breach and must be reported to the Data Protection Commissioner.

10.5 The Domestic Homicide Review Officer will act as a conduit for all information moving between the Chair, IMR Authors, Panel Members and the DHR Panel.

Appendix 2.

NOTE – LETTER ANNONYMISED

Letter from Jehovah's Witnesses British Bethel Chelmsford to DHR Author

Malcolm Ross MSc, Domestic Homicide Review

Sent by e-mail 8.10.20

Dear Mr Ross:

Re: Domestic Homicide Review – Mrs [Poppy]

We write further to your e-mail dated 8 September 2020, and your telephone call with our representatives, […….] and […….] on 1 September 2020. Thank you for setting out your concerns in writing.

We understand that you are chairing a Domestic Homicide Review (DHR) into the tragic death of Poppy, who was killed by her husband (Dad) on Monday, [date] 2020.

We have investigated this matter and set out our findings below.

Background

Mr and Mrs were Jehovah's Witnesses and they associated with the [local] Congregation of Jehovah's Witnesses (the Congregation). However, due to physical health implications they had not been able to attend meetings at the Congregation's place of worship for several months prior to the date of Mrs [Poppy's] death.

We understand that a few individuals who also associated with the Congregation and were close to the [couple], had been voluntarily checking on them from time to time. One individual became particularly concerned about their ability to look after themselves physically and Mr [Dad's] mental health, including his forgetfulness. On [date] 2020, two of the local elders (religious ministers) of the Congregation shared those concerns with their son, who is not associated with the Congregation.) [The son] confirmed that he was aware of the situation and that he did not require any assistance.

Sadly, in the early hours of [date] 2020, Mr [Dad] killed his wife.

Safeguarding vulnerable adults

In your meeting with Messrs […..] and […] and your e-mail, you referred to the Care Act 2014 (the Act). We understand that the Act imposes duties on local authorities in relation to safeguarding adults. After reviewing the Act, we have not been able to identify anything in that legislation which applies to congregations of Jehovah's

Witnesses. If you are able to point us to a specific provision, we will be happy to consider this further, and provide a response.

As Messrs […..] and […..] discussed with you briefly in the telephone call on [date] 2020, congregations of Jehovah's Witnesses do not arrange or supervise any activity which involves providing personal care for elderly or vulnerable persons. Congregations of Jehovah's Witnesses provide spiritual support and guidance for congregants and the wider community. Two religious services are held each week, at which congregants meet together (currently by zoom) to worship and learn about the Bible. Congregants come from a diverse demographic and include families with young children, single men and women, married couples, as well as elderly individuals.

As practising Christians, Jehovah's Witnesses naturally take a genuine personal interest in the welfare of all in the congregation, especially those who are elderly or more vulnerable. Jehovah's Witnesses provide Bible-based guidance on how individuals can take reasonable care of their health and how individuals can support families in providing care for their elderly relatives. Individual congregants may assist elderly congregants with routine tasks, for example, help with shopping, cleaning, transport to congregation meetings. However, this would be a personal arrangement and not a congregation service or activity.

Mr […] (Elder) interaction with the [couple]

We understand that you have spoken with Mr […], who serves as an elder (religious minister) in the Congregation, and you have some concerns about his response to comments made by [Dad] shortly before he killed his wife. We set out below our understanding of the facts surrounding his interaction with the [couple].

Some weeks prior to the tragic death of [Poppy], [Dad] and [Poppy] had asked Mr […] to assist them with some personal matters involving wills and power of attorney. Mr […] was employed as a police officer for two years and the [couple] felt that he was well placed to assist them with these personal issues. Mr […] agreed to assist them as a personal favour in his capacity as a friend of the family.

It is important to note that the elders of the Congregation did not arrange or approve for Mr […] to provide this personal assistance. Elders of Jehovah's Witnesses are religious ministers and as such provide spiritual assistance to congregants. As elders, they do not get involved in congregants' personal, financial matters. If an elder personally decides to assist a congregant or others with such matters, he does so in his personal capacity, and not in connection with any congregation activity or responsibilities as an elder.

Mr […] arranged to visit the [couple] on [date] 2020, with the [couple's] solicitor to finalise the personal matters with which he was assisting. The [couple's] son was aware that his parents had asked for the assistance of Mr […] and approved of this arrangement. After the [couple's] solicitor left, [Dad] made a comment about killing himself and Poppy. Dad made the comment in the presence of [Poppy] and Mr. […], and [Poppy] did not appear concerned by the comment. The comment was made in the context of [Dad] expressing his frustration with his forgetfulness and life in general. Mr […] had not heard [Dad] make any such statement before. He was not aware of any previous threatening, abusive or violent conduct by [Dad] to his wife or anyone else. Thus, Mr […] did not in any way view [Dad's] statement as a credible

threat to commit murder and suicide. As stated above, Mr [….] worked as a police officer for two years. Based on his experience and the circumstances at the time, Mr [....] considered that the statement was a throwaway comment as a result of stress and briefly shared a Scripture from the Bible with [Dad] about dealing with anxiety. Mr […] did not mention the matter to anyone.

We understand the [couple's] son, was due to visit his parents over the weekend. Tragically, in the early hours of [date] 2020, [Dad] killed his wife. [Dad] contacted Mr [….] on 17 February 2020, and told him that he had killed his wife. Mr [….] was not sure whether or not to believe such a shocking statement, but travelled to the [couple's] residence to check and called the police en-route.

In summary:

• Neither Mr or Mrs …. were under the physical care or supervision of the Congregation.

• Mr and Mrs …… had not been at congregation meetings for many months. Therefore, the only contact they had with congregants was with any who made personal visits on them.

• The Congregation was not aware of any risk to the health or life of [Poppy].

• Mr [….] heard the comment made by [Dad] on a personal visit, unconnected with any Congregation activities or his responsibilities as an elder.

• [Dad] had no known history of being threatening, abusive or violent to his wife (or anyone else).

• Mr [….] (a former police officer) did not believe that [Dad's] comment was a serious threat to kill. Based on his experience and the circumstances, he viewed it as a throwaway comment, caused by stress over various matters. This was particularly the case since the comment was made in [Poppy's] presence and she did not appear concerned.

• [Poppy] was not vulnerable mentally and there was no reason for Mr [….] to think that she was at risk.

Conclusion

In all the circumstances, we do not consider that Mr [….] acted inappropriately in relation to the isolated, throwaway comment of [Dad]. In any event, in assisting the [couple], Mr [….] was acting in his personal capacity and not in connection with any activity of the Congregation or his responsibilities as an elder.

We trust this is helpful and will assist you and the panel in your review of this tragic event.

Yours sincerely,

Legal Department

Appendix 3.

Dear Mr Ross:

As you correctly observe, the letter was authored by the Legal Department of Christian Congregation of Jehovah's Witnesses. One of our solicitors, , is taking the lead on this matter, so please mark any further correspondence for his attention.

Yours sincerely,

Legal Department

Christian Congregation of Jehovah's Witnesses

1 Kingdom Way, West Hanningfield, CHELMSFORD, CM2 8FW

Tel: +44 (0) 20 8371 3416

From: Malcolm Ross
Sent: 8 October 2020 14:19
To: InboxLGL.GB <
Cc: Stavroula Sidiropoulou
Subject: RE: Domestic Homicide Review -

Dear Legal Department.

I thank you for your letter received today and thank you for your help.

For the sake of regularity, can I ask please who is the author of the letter? It is signed by the Legal Department and I would prefer to respond to an individual as this case contains sensitive information that I would prefer to share with the author as an individual.

I am sure you understand.

Kind regards

Malcolm Ross

Appendix 4.

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Coordinating Committee Christian Congregation of Jehovah's Witnesses 1 Kingdom Way West Hanningfield Chelmsford, Essex CM2 8FW E-mail: [redacted]
1	**SENIOR CORONER** I am S McGovern, Senior Senior Coroner, for the Senior Coroner area of Warwickshire
2	**SENIOR CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Senior Coroners and Justice Act 2009and regulations 28 and 29 of the Senior Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** I opened an investigation on 27 February 2020 into the death of [redacted] late of [redacted] I concluded the inquest on 28 April 2021 and returned a conclusion that she was unlawfully killed.

4	**CIRCUMSTANCES OF THE DEATH** [redacted]s unlawfully killed on [redacted]20. She was stabbed 49 times as she was sleeping in her own home. She was 80 years old and vulnerable by means of physical disabilities. She was a devout Jehovah's witness – as was the perpetrator. The perpetrator made at least one comment to an Elder of the Jehovah's Witnesses indicating that he proposed to kill [redacted] stabbing her.
5	**SENIOR CORONER'S CONCERNS**
	During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – During the course of the inquest it was accepted that the Christian Congregation of Jehovah's Witnesses (CCJW) do not have any policy regarding safeguarding of vulnerable adults who are members of the congregation. The issue of such a policy was raised by the author of the Domestic Homicide Review into [redacted]eath with the CCJW in October 2020. The reply from the CCJW is unclear whether they propose to adopt such a policy or not.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25h June 2021. I, the Senior Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Senior Coroner and to the following InterestedPersons: (a) [redacted] – son of [redacted] I am also under a duty to send the Chief Senior Coroner a copy of your response. The Chief Senior Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it usefulor of interest. You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Senior Coroner.
9	**30th April 2021** **[** **Senior Senior Coroner Mr. S McGovern**

Appendix 5

Christian Congregation of Jehovah's Witnesses
1 Kingdom Way, West Hanningfield, Chelmsford CM2 8FW Telephone 020 8906

17th June, 2021

Mr Sean McGovern

HM Senior Coroner for

WarwickshireWarwickshire

Justice Centre Newbold

Terrace LEAMINGTON SPA

CV32 4EL

Re: Regulation 28: Report to Prevent Future Deaths -

Dear Mr McGovern:

I am writing on behalf of Christian Congregation of Jehovah's Witnesses in Britain in response to your *Regulation 28: Report to Prevent Future Deaths* of 30th April, 2021, concerning .

Jehovah's Witnesses have for many years had a long-standing religious practice, set out in their religious publications, with respect to vulnerable adults. The following summarises that religious practice.

At the outset, it is important to keep in mind that Jehovah's Witnesses endeavour to base their beliefs, practices and everyday way of life on Bible principles and "the law of the Christ." (Galatians 6:2) Consequently, Jehovah's Witnesses feel a deep sense of moral obligation to observe Jesus' command to 'love their neighbour as themselves.'—Matthew 22:38, 39.

There are no closer neighbours than members of our own family. Therefore, understandably, the Bible places the primary responsibility of caring for the elderly on family members, especially adult

children.[22] In his first letter to Timothy, chapter 5, verse 4, the Bible writer, Paul, said: "If any widow has children or grandchildren, let these learn first to practice godly devotion in their own household and to repay their parents and grandparents what is due them, for this is acceptable in God's sight."

However, where an elderly person has no children, or where responsible adult children need and are happy to receive help in caring for their parents, individuals within congregations of Jehovah's Witnesses are moved by love of neighbour to offer necessary support and assistance. The same principle would apply to any vulnerable adult.

The Bible exhorts Christians to 'look out for the interests of others,' especially those who are weak, vulnerable or disadvantaged. (Philippians 2:4; 1 Thessalonians 5:14) For example, the Bible states: "The form of worship that is clean and undefiled from the standpoint of our God and Father is this: to look after orphans and widows in their tribulation." (James 1:27) Such 'looking after' involves not simply offering emotional support and words of comfort, but also practical assistance whenever needed.

The 15th March, 2014, edition of *The Watchtower*, pages 21-29,[2] published by Jehovah's Witnesses, included two articles for congregation study on the subject of caring for vulnerable adults, particularly the elderly. Those articles included religious guidance on the following subjects:

- The responsibility of the family in providing care for the elderly (pages 21-22)
- Circumstances when the congregation would assist the elderly (pages 22-23)
- Assisting and referring the elderly to governmental and social programmes (page 23-24)
- Providing pastoral support and emotional encouragement to the elderly (pages 24-25)
- Religious guidance on providing care for the elderly (pages 25-29)

Additional guidance has also been provided in *The Watchtower* of 15th July, 1988, which states on page 22:[23] "The elders might determine just what is required. Does the elderly one need help shopping? Is he lonely or in need of encouragement? … It may take several visits and chats before the full picture emerges… Once the needs of an elderly person are known, specific arrangements can be made." *The Watchtower* of 15th August, 2008, page 19, adds:[24] "In many congregations, the elderly are being cared for in an exemplary manner. Loving brothers and sisters help them with shopping, cooking, and cleaning… Whenever possible, elders make sure that practical arrangements are implemented in order to meet the needs of older ones in the congregation."

In making such practical arrangements, the congregation does not replace or substitute for those who have the primary responsibility to provide care to an elderly or vulnerable person. Rather, the congregation is available to complement and support the efforts of those with the primary caregiving responsibilities.[25] Any arrangements involving the congregation are subject to the full cooperation of those receiving care, their families and primary caregivers. In accord with the Bible's

[22] What Does the Bible Say About Caregiving for Elderly Parents? Help for Caregivers (jw.org) [2] The Watchtower—Study Edition, March 15, 2014 (jw.org)

[23] Meeting the Needs of Our Older Ones—A Christian Challenge — Watchtower ONLINE LIBRARY (jw.org)

[24] https://www.jw.org/en/library/magazines/w20080815/Jehovah-Tenderly-Cares-for-His-Elderly-Servants/

[25] Caring for the Caregiver—How Others Can Help — Watchtower ONLINE LIBRARY (jw.org)

injunction to “show honour” to the elderly, help is offered in a way that allows individuals to retain their dignity and control how they choose to live.[26]— Leviticus 19:32.

Determining what is required in helping an elderly or vulnerable person includes being alert to signs of decline and to taking reasonable steps to prevent harm and reduce the risk of abuse or neglect.[27] Where such a risk may exist, Christian love would move the individuals involved to alert those in positions of responsibility, such as family members, caregivers or relevant authorities.

Unlike some other religions, congregations of Jehovah’s Witnesses do not carry out any activities that formally bring vulnerable adults into their care. For example, our congregations do not operate or sponsor care-homes, day-care centres or any activities that assume responsibility for the care of vulnerable adults. Therefore, it is our understanding that congregations of Jehovah’s Witnesses do not fall within the scope of legislation and regulatory guidance concerning those who work with or provide care to vulnerable adults, thus obviating the need for a formal policy. Nonetheless, although not having a legal or regulatory obligation to do so, as made clear in the above-mentioned religious guidance in *The Watchtower* magazine, Jehovah’s Witnesses consider it a Christian duty to do what they reasonably can to provide support to vulnerable adults and their family members.

It is the view of Jehovah’s Witnesses that a formal policy is not necessary to move them to demonstrate Christlike love toward individuals who need comfort and support for a variety of reasons.
Nevertheless, regardless of whether a legal obligation exists, Jehovah’s Witnesses continue to be interested in caring for the elderly and vulnerable and welcome constructive suggestions that may help create even further improvements.

I hope these comments, and the supporting references, help make clearer the position of Jehovah’s Witnesses in the matter of caring for vulnerable adults associated with our congregations.

Yours sincerely,

[26] Providing Care for the Elderly, paragraph 13 — Watchtower ONLINE LIBRARY (jw.org)
[27] Providing Care for the Elderly, paragraph 17 — Watchtower ONLINE LIBRARY (jw.org)

Home Office Letter

To be attached once received.

Reply to Home Office letter