Safer Barnsley Partnership

Executive Summary
Domestic Homicide Review

Name: Lucy

Died: May 2022

Chair and Author: Ged McManus

Assisted by: Carol Ellwood Clarke QPM

Date: November 2023

1 The Review Process

1.1 This summary outlines the process undertaken by the Safer Barnsley Partnership, Domestic Homicide Review panel in reviewing the murder of Lucy, who was a resident in their area. The panel would like to offer their condolences to Lucy's family on their tragic loss.

1.2 The following pseudonyms have been used in this review to protect the identities of the victim, perpetrator and others referred to in the review.

Name	Who	Age	Ethnicity
Lucy	Victim	55	White British
Dennis	Perpetrator and Lucy's partner	67	White British
Alex	Lucy's adult child	Not disclosed	White British

1.3 Lucy and her partner, Dennis, had been together for approximately 11 years and lived with each other in Lucy's house in the Barnsley area, which she owned outright. During early 2022, the couple split up, and Dennis moved out of the house. It seems that this split was temporary, and that Dennis later moved back into the house.

1.4 On a day in May 2022, Lucy did not arrive at work for a planned meeting. This caused concerned colleagues to contact the police. The police forced entry to the property and found both Lucy and Dennis dead. A note, apparently written by Dennis, indicated that he had killed Lucy and then killed himself.

1.5 Following the discovery of the death of Lucy and Dennis, a police investigation began to establish the facts. The police made a referral to the Safer Barnsley Partnership for consideration of whether a Domestic Homicide Review should be conducted.

1.6 At a meeting on 16 June 2022, the Safer Barnsley Partnership agreed that the circumstances of the case met the criteria for a DHR and agreed to conduct a Domestic Homicide Review. The Home Office was informed on 11 January 2023, following the first DHR panel meeting.

1.7 The first DHR panel meeting took place on 5 January 2023. The first meeting of the DHR panel determined the period the review would cover. The Review Panel

determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce Individual Management Reviews. Lucy's employer agreed to provide a narrative report. The Chair provided training to Individual Management Review (IMR)[1] authors to assist in the completion of the written reports

1.8 At the point of the first meeting of the DHR panel, some elements of the police investigation were not concluded. The coroner had not set a date for an inquest. The Chair of the DHR notified the coroner of the review; subsequently, the coroner indicated for the DHR to be concluded prior to the inquest taking place. In order to facilitate this, the coroner gave permission for the police to disclose witness statements – taken for the purposes of the coroners' enquiry – to the DHR. These are referenced appropriately in the report.

1.9 The panel met four times: responses and additional queries outside of these meetings were addressed via telephone and email. The DHR panel carefully considered the material provided by agencies and the contributions made by the family. Following the DHR panel's deliberations, a draft overview report was produced: this was discussed and refined at further panel meetings.

1.8 Lucy's mum and her adult child, Alex, were both assisted by a Victim Support Homicide Worker. The Chair of the review wrote to both Lucy's mum and Alex, enclosing the relevant Home Office leaflet. The letters inviting Lucy's family to contribute to the review, were given to them (personally) by their Victim Support Homicide Worker, and they agreed to contribute to the review.

1.9 The Chair of the review met Lucy's mum and Alex, who were assisted in the meeting by their Victim Support Homicide Worker. Their contribution to the review is appropriately referenced throughout the report.

1.10 After an extensive period of consultation, both Lucy's mum and her adult child provided feedback and had a number of questions, which resulted in revisions to the report. They were supported in this by their Victim Support Homicide Worker. The report was concluded in November 2023.

1.11 **Lucy's Employer**

[1] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review

1.12 Lucy's employer agreed to contribute to the review, and a senior manager sat on the DHR panel. The employer provided a narrative report about Lucy's employment.

1.13 Lucy had worked for her employer since 2005 and her role involved carrying out visits in the community on a regular basis.

1.14 Over the years prior to Lucy's murder, Lucy's employer became aware of Lucy's heath concerns, which sometimes resulted in periods of sickness absence. She was absent from work through illness from August 2021 to April 2022.

1.15 **Work Friends and Colleagues**

1.16 The Chair of the review wrote to Lucy's work friends and colleagues, inviting them to contribute to the review. The letter included the appropriate Home Office leaflet and was distributed (personally) to Lucy's colleagues by her employer.

1.17 As a result of the invitation to contribute to the review, two of Lucy's work friends met with the Chair of the review.

1.18 **Contribution from Friend 1**

Friend 1 described Lucy as a kind, generous, and genuine person who would do anything for everyone. Lucy was open and said things as they were. Lucy had the reputation of being a strong character in the work environment, but this was only a front and was because she was passionate.

1.19 Friend 1 had known of Lucy for over 20 years, through working for the same employer. However, it was only after they began working together, around 2018/2019, that they became close friends: speaking at work and daily outside of work via telephone calls. Friend 1 described that when Lucy first started working in her team, she was vulnerable due to her alcohol use, and there was a lot of support provided. After a period of time, it was known that Lucy had started to drink alcohol again.

1.20 Lucy was sociable in the office, for example, often preparing and sharing food for everyone, feeding everyone, and bringing in items such as colouring books for colleagues' children. Lucy and Friend 1 did not socialise outside of the office, which was linked to Covid-19 and Lucy's health conditions, but often spoke on the telephone outside working hours.

1.21 **Knowledge of Dennis**

Friend 1 described Dennis as 'solitary', and that he did not appear to have friends outside his relationship with Lucy. It was known that he had money and owned properties, but these properties were thought to be lived in by his family members. Lucy told Friend 1 that Dennis was receiving about £3000 per month from a pension.

1.22 **Knowledge of Lucy and Dennis's Relationship**

Friend 1 said that, as a couple, Lucy and Dennis appeared happy and solid together in their relationship. Lucy loved cats and dogs. They owned a caravan in France and went to France for around three weeks every year. Lucy told Friend 1 that there was no intimacy in her relationship with Dennis, which Lucy was happy about. They were more like companions.

1.23 Friend 1 described how she was aware that arguments had started in the relationship prior to Lucy's death, and that Lucy and Dennis had split up in January 2022. The arguments were over financial matters and an issue over an expensive watch, which Dennis had promised to someone. Lucy said that Dennis did not pay towards the house or bills. Lucy had funded a new kitchen.

1.24 Lucy told Friend 1 that Dennis had turned off Lucy's landline and mobile phone, and that this had caused Lucy distress because the landline was the number that had belonged to her grandmother and had sentimental value (Lucy lived in and owned her grandmother's former home). Friend 1 had spoken to Lucy about making a will, to ensure that financial matters were in order for Lucy's adult child, Alex[2].

1.25 Friend 1 stated that after Lucy and Dennis split up in January 2022, Dennis started to watch the house and watch Lucy. This made Lucy nervous, and as a result, Lucy had CCTV and a new lock installed on the gate outside the property. Lucy told Friend 1 that Dennis had stated that he was going to report Lucy to the police for driving whilst under the influence of alcohol. Friend 1 described how Lucy and Dennis got back together after their dog had fallen ill and they had to take the dog to the vet for treatment. After this, they started spending time together.

1.26 **Work**

Friend 1 provided some examples of Lucy's work ethic, which included –

- Working in a soup kitchen and providing food: she would usually be joined by Dennis.

[2] A pseudonym agreed with Lucy's family.

- Lucy and Dennis taking food and other items to a tenant who had recently given birth and was short of money.
- Lucy would often source items for tenants who were struggling financially.
- Dennis would often drive Lucy to work appointments. On the face of it, this was thought to be in order to ensure that Lucy did not have to worry about being over the alcohol limit to drive herself (Lucy's employer was not aware of this).
- Lucy was worried about the alcohol testing that was to be introduced at work and had purchased her own breathalyser (over £300) to test her alcohol levels.

1.27 **Domestic Abuse**

On occasions, Friend 1 had seen Lucy at work with bruises (mainly on her arms), which was thought to be linked to Lucy's vulnerability and falling over. At no stage did Friend 1 think that this was due to domestic abuse, and nothing about Lucy's presentation and explanations led her to believe otherwise. Friend 1 stated that if Lucy was being physically abused by Dennis, then she strongly felt that Lucy would have spoken out about this, told her, and left the relationship, such were her strong values.

1.28 Within the workspace, there are Well-being Champions that are freely advertised for staff to contact. There is information on the company Intranet*.
Friend 1 stated that one of the things that may have prevented Lucy seeking support, was going to a venue or agency and the risk of meeting a client, etc.

1.29 Two other colleagues alerted the police when they became concerned that Lucy did not attend an important work meeting. Information in their statements to the police, included that a third colleague had spoken to Lucy the evening before her death, and everything had appeared fine. Lucy had arranged work appointments for the day that she was found deceased.

1.30 * Lucy's employer provided the following information:
There has been a Domestic Abuse Policy in place since 2018, and this is available on our intranet for all employees to access. The information details steps to look out for should an individual be suffering domestic abuse, and includes support available and signposts people to a number of agencies, including IDAS. We also have a number of Wellbeing Champions across the organisation from numerous different service areas. Staff are able to access this confidential support, should they wish.

1.31 **Contribution from Friend 2**

Friend 2 described Lucy as a 'force to be reckoned with'. A physically small but an emotionally strong person who would stand up for what she believed in. At the same time, Friend 2 was aware of Lucy's vulnerabilities, and especially in 2022, saw that Lucy was struggling physically, for example, with pain in her limbs.

1.32 Friend 2 first met Lucy when (aged 18) Friend 2 worked for a different agency. Later, after a move of agency, Friend 2 and Lucy worked together. Friend 2 described how Lucy sometimes tried to shield her from bad news and did not always share difficult health news. Friend 2 thought that this was because she was younger than Lucy and had known Lucy from being a teenager.
Lucy was a kind and generous person who would often give friends and colleagues small gifts. Lucy bought small gifts for Friend 2's children when they were doing exams at school.

1.33 **Knowledge of Dennis**
Friend 2 previously thought that Dennis was a good man and had been comfortable in his company. Dennis was generous with his time and had helped Friend 2 and her family on a number of occasions. Friend 2 was aware that Dennis owned properties and that Lucy expressed discontent that Dennis's sibling lived in one of the properties.

1.34 **Knowledge of Lucy and Dennis's Relationship**
Friend 2 had no sense of any domestic abuse in Lucy and Dennis's relationship. They appeared content with each other until their relationship breakdown in January 2022. Friend 2 knew that Dennis had spent a lot of time on an extension at Lucy's house. When this was finished, Lucy was pleased and proud about it. Lucy told Friend 2 that Dennis would often have food ready for her when she got home from work.

1.35 After the relationship breakdown, Lucy told Friend 2 that Dennis had cut off the utilities at her house and cancelled her mobile phone contract. Friend 2 was concerned about this due to Lucy's poor health and was glad when she quickly obtained another mobile phone. At this time, Lucy became concerned and didn't want to leave the house because she thought Dennis would be watching her. Friend 2 arranged for the CCTV at the house to be modified in order to make Lucy feel better.

1.36 In general, Lucy had her own money and was able to buy the things that she wanted, for example, nice clothes or a pair of expensive boots. Lucy told Friend 2 that she was estranged from Dennis's family, and that Lucy and Dennis would

sometimes argue about this. Lucy had fallen out with one of Dennis's siblings and would not agree to be in the same room as them.

1.37 **Work**

Friend 2 described a very close working relationship with Lucy, and especially during Covid-19 lockdown, they were in touch all the time. Friend 2 admired Lucy's work ethic and her willingness to help people. On a number of occasions, Friend 2 had seen Lucy spend her own money to help clients with food and small household items. After Lucy's hospital admission in August 2021, colleagues were aware of Lucy's poor health and how she was physically impacted by this. For example, she struggled to walk up steps or for long distances. Colleagues who knew Lucy was struggling, rallied around to make sure that she was organised at work and that her work did not suffer.

1.38 Friend 2 commented that Lucy was not very IT literate. Colleagues would joke that Lucy was jinxed, as things would often go wrong for her. In this context, Friend 2 was not surprised that Dennis would have access to utility accounts, etc., as Friend 2 thought that Lucy may struggle to manage them herself online.

1.39 **Nail Technician**

Following Lucy's death, the police obtained a statement from a nail technician who visited Lucy at home, regularly, from October 2021 until Lucy's death. Appointments would normally be every three or four weeks and would take place in the dining room of Lucy's home. Dennis was always present and would take part in the conversation. Specific incidents are referenced in section 13.3 of the report.

2 Contributors to the Review

2.1	**Agency**	**Contribution**
	South Yorkshire Police	IMR
	Barnsley Hospital NHS Foundation Trust	IMR
	South West Yorkshire Partnership NHS Foundation Trust	IMR
	Yorkshire Ambulance Service	IMR

NHS South Yorkshire ICB – Barnsley	IMR
Barnsley Recovery Steps (Humankind)	IMR
Lucy's employer	Narrative report

2.2 As well as the IMRs, each agency provided a chronology of interaction with Lucy and Dennis, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of Lucy or the perpetrator, nor had any involvement in the provision of services to them.

2.3 The IMRs in this case focussed on the issues facing Lucy. Further elaboration by IMR authors during panel meetings was invaluable. They were quality assured by the original author, the respective agency, and by the panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

3 Members of the Domestic Homicide Review Panel

3.1	Ged McManus	Chair and Author
	Carol Ellwood-Clarke	Support to Chair and Author
	Rosemary Clewer	Senior Commissioning Manager, Stronger, Safer & Healthier Communities Business Unit, Barnsley Metropolitan Borough Council
	Calise Martin	Case Review and Policy Officer, South Yorkshire Police
	Abigail Akers	Intelligence Researcher, South Yorkshire Police
	Rebecca Slaytor	Named Nurse, Adult Safeguarding, Barnsley Hospital NHS Foundation Trust
	Emma Cox	Associate Director of Nursing, Quality and Professions, South West Yorkshire Partnership NHS Foundation

Catherine Holiday	Named Professional for Safeguarding Yorkshire Ambulance Service
Gillian Pepper	Adult Safeguarding Nurse Specialist, NHS South Yorkshire ICB – Barnsley
Claire McEvoy	Area Manager, Barnsley Recovery Steps (Humankind)
Katherine Allott-Stevens	Head of Estate Services, Berneslai Homes
Donna Clark	Area Manager IDAS (Domestic Abuse Service)
Alice Barker Milner	Policy Officer for Domestic Abuse, Barnsley Metropolitan Borough Council, Healthier Communities
Al Heppenstall	Housing and Case Management Team Lead, Barnsley Metropolitan Borough Council
Amy Hoyle	Contracts and Relationships officer, Domestic Abuse, Barnsley Metropolitan Borough Council

3.2 Each panel member was independent, having no previous knowledge of the subjects nor any involvement in the provision of services to them. The exception was the representative of Lucy's employer.

4 Chair and author of the overview report

4.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, set out the requirements for review Chairs and Authors.

4.2 Ged McManus was chosen as the DHR Independent Chair and Author. He was judged to have the skills and experience for the role. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Barnsley or an adjoining authority). Ged served for over thirty years in different police services in England. Between 1986 and 2005, he worked for South Yorkshire Police – a contributor to this review – before moving to another police service. The commissioners of the

review were satisfied of his independence, given the length of time since he had any involvement with South Yorkshire Police.

4.3 Carol Ellwood-Clarke supported the Chair. She retired from public service (British policing) in 2017, after thirty years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives.

4.4 Between them, they have undertaken over sixty reviews including the following: child serious case reviews; Safeguarding Adult Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and, have completed the Home Office online training for undertaking DHRs. They have also completed accredited training for DHR Chairs, provided by AAFDA[3].

5 Terms of Reference

5.1 The purpose of a DHR is to:

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

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

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

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

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

[3] Advocacy After Fatal Domestic Abuse.

Highlight good practice.

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

5.2 Timeframe under Review

The review covers the period from 11 November 2018 to Lucy and Dennis's deaths in May 2022.

This time period was chosen because even though the couple had been together for over 10 years, there had never been any report of domestic abuse in their relationship. The panel therefore looked for significant events that may reasonably indicate a start point for the review. In November 2018, Lucy sought help from alcohol services. The panel thought that this was a significant event and chose to start the timeline of the review from that point.

5.3 Subjects of the DHR

Victim: Lucy, aged 55 years

Perpetrator: Dennis, aged 67 years

Specific Terms

1. What indicators of domestic abuse did your agency have that could have identified Lucy as a victim of domestic abuse, and what was the response?

2. What knowledge did your agency have that indicated Dennis might be a perpetrator of domestic abuse against Lucy, and what was the response? Did that knowledge identify any controlling or coercive behaviour by Dennis?

3. How did your agency assess the level of risk faced by Lucy? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?

4. How did your agency respond to any mental health issues, substance misuse, and/or self-neglect, when engaging with Lucy and Dennis?

5. What services did your agency provide for Lucy and/or Dennis; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk?

6. When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

7. Were single and multi-agency policies and procedures, including the MARAC, followed? Are the procedures embedded in practice, and were any gaps identified?

8. Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Lucy and/or Dennis, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to Covid-19.

9. What knowledge did family, friends, and employers have that Lucy was in an abusive relationship, and did they know what to do with that knowledge?

10. Were there any examples of outstanding or innovative practice arising from this review?

11. What learning has emerged for your agency.

12 Does this learning appear in other Domestic Homicide Reviews commissioned by Barnsley Community Safety Partnership?

6 Summary chronology

6.1 Lucy

6.1.1 Lucy's mum says that Lucy was a genuine, caring, and thoughtful person who would do anything to help anyone. Lucy spent a lot of time with her mum, and they got on well.

6.1.2 Lucy had a child, Alex, with her then husband. Lucy split from her husband when the child was around two years old.

6.1.3 Lucy and Alex would often visit Lucy's mum, and Sunday lunch was an event they all looked forward to. Lucy and Alex had a close relationship and enjoyed many activities together, such as kickboxing. Alex says that Lucy was outgoing and had many friends.

6.1.4 Both Lucy's mum and Alex were aware of Lucy's long-standing health issues related to alcohol, which they thought may have been present before she met Dennis.

6.2 Dennis

6.2.1 Dennis was the youngest of five siblings. One of his siblings provided a statement to the police, and some of the information from that statement is used here.

6.2.2 Dennis was a healthy and happy young man who gained a qualification in welding when he left school. He became a plant manager for British Coal in his early thirties and went on to undertake similar roles in Africa and America.

6.2.3 Dennis was married and divorced twice. During his second marriage, Dennis and his wife had a substantial lottery win. At the time of his death, Dennis still owned properties that had been bought with the money. His second marriage ended in around 2010. Dennis moved into Lucy's house in 2011.

6.3 Lucy and Dennis's Relationship

6.3.1 Lucy's mum and Alex told the Chair of the review how soon after Lucy's relationship with Dennis started, it was difficult to see Lucy without Dennis, as they would always be together.

6.3.2 Lucy's mum stopped hosting Sunday lunch because it became unpleasant. She did not enjoy Dennis's company and thought that he had a superior attitude towards her and the rest of the family.

6.3.3 Dennis began building an extension at the rear of Lucy's house. This went on for seven years and caused the house to be very dark at the rear, as the existing walls could not be opened up until the extension was watertight. Previously, Lucy had enjoyed cooking and often entertained friends, but this gradually stopped because she became a little embarrassed at the state of her house. Lucy tried to go out for meals with Alex whenever possible so that Alex didn't have to visit the house: Dennis was usually included. Alex tried to buy tickets for the theatre and other events for Christmas and birthdays so that Alex and Lucy could spend some

time together. This eventually stopped, as Lucy would cancel or make an excuse not to attend. It seemed that Lucy's world became much smaller during her relationship with Dennis.

6.3.4 When Alex graduated from university, they only requested two tickets to the ceremony so that Lucy and Alex's grandmother could attend. This was deliberate act, so that they could spend some time together without Dennis.

6.3.5 Lucy's family described Dennis as a hoarder, and as a result, Lucy's house gradually became more untidy and filled with his possessions. Alex's former bedroom was used as storage for Dennis's tools and other things.

6.3.6 Dennis's sibling said that there would often be arguments in the relationship, and Lucy would ask Dennis to leave.

6.4 Events During the Timescale of the Review

Note: Both Lucy and Dennis had many routine medical appointments for a number of issues. Most appointments are not listed here. Both suffered from diabetes.

6.4.1 On 31 October 2018, Lucy was admitted to Barnsley Hospital for treatment for deranged liver function. She was diagnosed with chronic liver disease due to alcohol. Lucy stayed in hospital until 5 November 2018. A referral was made by the hospital to Barnsley Recovery Steps.

6.4.2 On 6 November 2018, Lucy completed a structured assessment with Barnsley Recovery Steps for entry into their substance misuse service, following referral from Barnsley Hospital. The assessment was completed at Lucy's home.

Lucy reported that her recent hospital admission scared her and made her realise her drinking needed to be addressed. Lucy gave consent to all forms of contact, should she disengage. She also consented for information to be shared with Dennis, her employer, pharmacy, and GP.

Dennis was present during the assessment.

6.4.3 Lucy remained in treatment with Barnsley Recovery Steps until 17 January 2019, when she reported being abstinent from alcohol for 10 weeks. She was discharged from the service and understood that she could refer herself back into

the service at any time. In total, there were six face-to-face appointments in this episode of treatment. Lucy was accompanied by Dennis for all of them.

6.4.4 On 27 August 2021, Lucy was admitted to Barnsley Hospital and treated for E. coli in urine, hospital acquired pneumonia, and alcoholic liver disease. Lucy's treatment included an alcohol detox programme. She was discharged home on 28 September 2021. During this hospital admission, Lucy was supported by the hospital alcohol care team. Lucy did not want a referral to Barnsley Recovery Steps, as she thought that she may come across some of her own work clients. As a result, the hospital alcohol care team kept in touch with Lucy regularly (by telephone) until 28 October, when Lucy reported being abstinent from alcohol since being in hospital and did not require further support.

6.4.5 On 31 August 2021, Lucy became absent from work due to illness.

6.4.6 Lucy's family told the Chair that following her discharge from hospital, Lucy joined an online Alcoholics Anonymous group and attended a number of meetings, which she did not find easy.

Note: Alcoholics Anonymous do not maintain a record of meeting attendance, and no information on this is available.

6.4.7 On 15 January 2022, Dennis contacted the police. Dennis said that he had recently split up from Lucy after an 11-year relationship. Dennis said that someone he believed to be Lucy, had sent messages from his Facebook account to a friend, alleging that he was having an affair with the friend's wife.

Officers attended, and Dennis was advised that this was a civil matter. He confirmed that he only wanted words of advice giving to Lucy, which the officer did over the phone. The officer reiterated to Dennis that there would be no criminal investigation. Dennis indicated that there were previous incidents of domestic issues with Lucy, but he would not provide any further detail when pressed and said that there was nothing in the last six months that would be within a window for prosecution. Due to this, no further action was taken. A DASH risk assessment was completed, with Dennis as the victim. The assessment showed a standard risk.

Lucy's child, Alex, told the Chair of the review that Dennis and Lucy shared a Facebook account in Dennis's name. This had started because some years previously, Lucy had been locked out of her own account for some reason.

6.4.8 At around this time, Lucy's family say that Dennis had the house telephone cut off and cancelled Lucy's mobile phone contract. Lucy had Covid-19 and was very isolated. Alex obtained a spare mobile phone so that Lucy could have contact with family members.

6.4.9 On 18 January 2022, Lucy sent a text message to Friend 2, stating that Lucy and Dennis had split up and that Dennis had cut off the utilities and her mobile phone. The text message was from a new number.

6.4.10 On 20 January 2022, Dennis had a routine appointment with a nurse at his GP surgery to discuss his diabetes. He said that: "he had been having a lot of stress recently with family life".

6.4.11 On 21 January 2022, Lucy telephoned the Barnsley Hospital alcohol care team and said that she had been drinking for eight or nine days following the breakdown of her relationship with Dennis. She was given advice. A member of the team rang Lucy the following day, but the telephone was not answered. A message was left, asking Lucy to make contact if she needed anything further. Nothing further was heard from Lucy.

6.4.12 On 6 February 2022, Lucy sent a text message to Friend 2, stating that Dennis had taken Lucy's car.

6.4.13 On 7 February 2022, during a telephone call between Lucy and a work colleague, the colleague formed the impression that Lucy was intending to take her own life. As a result, the colleague called the ambulance service, who attended at Lucy's home. When an ambulance crew attended at Lucy's home, Lucy was certain that she did not want to harm herself. Lucy said that she had drunk three bottles of wine and did have tablets in the house but was not going to take them. The ambulance crew asked Lucy to travel to hospital, which she declined. A mental capacity test was conducted, and Lucy was deemed to have capacity to make the decision not to travel to hospital. Written information was left with Lucy for an alcohol support service and details regarding a mental health support group. Lucy signed paperwork to confirm that she was remaining at home against medical advice.

6.4.14 On 14 February 2022, Dennis had an appointment with a GP. Dennis discussed with the GP, issues with family, Lucy, and physical and mental abuse. Dennis said that he had moved out of Lucy's house and was living with family. He had thoughts of self-harm but no direct plans to harm himself. Dennis was prescribed

sertraline[4]. At this time, Dennis's sibling was helping him to look for a property to rent, but the search was unsuccessful. In March 2022, Dennis sought a repeat prescription and disclosed some minor side effects of the medication. As a result, the prescription was changed to fluoxetine.

6.4.15 In February 2022, Lucy's nail technician visited her at home for a prearranged appointment. During this appointment, Lucy told the nail technician that the relationship with Dennis had ended. Lucy said that Dennis had taken her car, cut off the internet, and blocked her from accounts, for example, Netflix. The technician formed the impression that Dennis dealt with financial matters, as Lucy didn't seem to know what to do.

Lucy's mum and adult child thought that Dennis had probably helped set up Lucy's online accounts, which may account for the impression that Lucy didn't know what to do. Alex dealt with Lucy's estate after Lucy's murder, and she told the Chair of the review that Lucy dealt with her own financial affairs. Lucy and Dennis had separate bank accounts, and Lucy took care of all household bills. After the murder, Alex found papers indicating that Lucy had taken out a loan to pay for a new kitchen in the extension that had been built.

6.4.16 On 4 April 2022, Lucy contacted Barnsley Recovery Steps to refer herself into treatment for alcohol misuse. This was followed up, and on 26 April 2022, Lucy attended (in person) for a full assessment. Lucy's case was allocated to a recovery navigator who then met with Lucy in the following days. In total, there were four face-to-face appointments in this episode of treatment before Lucy's murder. Lucy was accompanied by Dennis for all of them.

6.4.17 In early May 2022, whilst out on a work visit together, Lucy wanted to call at home to show Friend 2 the work that had been done on the house and some new furniture. When they called into Lucy's house, Dennis was sat outside (on the new decking) reading a book. Friend 2 commented that Dennis had lost several stones in weight since she had last seen him before Christmas. Lucy and Dennis seemed content in each other's company on this occasion.

[4] Sertraline and fluoxetine are a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat depression, and also sometimes panic attacks, obsessive compulsive disorder (OCD), and post-traumatic stress disorder (PTSD).

6.4.18 In early May 2022, Lucy sent a text to her nail technician to arrange an appointment. In this text, Lucy said that she and Dennis were 'giving it another go'.

6.4.19 In early May 2022, Lucy's nail technician visited Lucy at home. Dennis was present. Unusually, Lucy was fully dressed and made up: she was normally in her dressing gown with no makeup on during these appointments. The dining room, which was normally cluttered with tools and other things, was unusually tidy. Lucy disclosed that Dennis 'was on his best behaviour' and had been doing some work in the garden. During the appointment, Dennis went outside and was cutting some trees and hedges. Lucy said that they had bought new garden furniture, which she showed to the nail technician.

6.4.20 During an evening in May 2022, Lucy and Friend 2 had a telephone call covering a number of issues and made arrangements for work the following day. Lucy seemed fine during this call. Friend 2 was always concerned about Lucy due to Lucy's health issues, and on this occasion, their concerns were at a normal level. Friend 2 did not feel that there was anything additional to be concerned about during this conversation.

6.4.21 Later the same evening, Dennis telephoned his sibling and asked them to go to see him at Lucy's house. When the sibling arrived, Dennis answered the door and handed over a bag containing some paperwork. The sibling heard Lucy shouting in the background.

6.4.22 The following day, Lucy and Dennis were found dead in their home.

7 Key issues arising from the review

- Dennis attended many health appointments and all recovery appointments with Lucy.
- There were no physical indicators of domestic abuse prior to Lucy's murder.
- Lucy was inhibited from accessing services as she feared bumping into her own clients.

Conclusions

8.1 Lucy and Dennis had been in a relationship since 2011 and had lived together in Lucy's house for almost all that time.

8.2 During the course of the relationship, Lucy suffered from health issues related to alcohol. Dennis attended all related appointments with Lucy as well as many other health related appointments. The panel reflected that whilst this itself may not be sinister, Lucy was consequently often not afforded the opportunity to speak to professionals privately.

8.3 Lucy's family were uncomfortable with some of Dennis's behaviour, for example, encouraging her to drink and listening in to her phone calls. However, no agency had knowledge of domestic abuse in the couple's relationship until concerns were raised by Dennis in January 2022. That incident was risk assessed by the police as standard risk, with Dennis recorded as the victim. Dennis intimated to both the police and his GP that there had been previous, historic incidents that had not been reported.

8.4 Dennis reported an incident to the police and relationship stress to his GP in January 2022. At the same time, it seems that he arranged for the utilities in Lucy's house to be cut off and her mobile phone contract cancelled. This behaviour was known by Lucy's family and friends, although it was not recognised as domestic abuse.

8.5 Lucy and Dennis later rekindled their relationship. Lucy proudly showed people the work that had been done on her home, together with new furniture. On the face of it (in May 2022), the couple were back together, and Lucy confided that Dennis was 'on his best behaviour'.

8.6 Lucy's family and friends who spoke to her in the days immediately before her murder, had no concerns for her safety beyond her existing health issues, and her murder was a great shock to them.

8.7 The panel would like to thank Lucy's family and friends for their input into the review.

9 LEARNING

This multi-agency learning arises following debate within the DHR panel.

9.1 **Narrative**

The panel acknowledged the potential benefits of people being supported by their partners at health and recovery appointments. The panel also highlighted that this involves risks.

Learning

The continuous presence of partners at health and recovery appointments may restrict the ability of a person to disclose safety concerns. Health and recovery professionals are likely to be inhibited from asking routine enquiry questions when partners are present.

Recommendation 1

9.2 **Narrative**

This case illustrates the complexity of domestic abuse indicators. There were no overt indicators of physical abuse for Lucy.

Learning

Further work needs to be done with professionals and the community to provide education around the wider non-physical aspects of domestic abuse.

Recommendation 2

9.3 **Narrative**

As a professional working in the area, Lucy was inhibited from accessing some services due to her fear of seeing her own clients whilst accessing services.

Learning

Professionals need to be able to have confidence that they can access appropriate services and that reasonable steps will be taken to afford them privacy.

Recommendation 3 and 4

10 **RECOMMENDATIONS**

DHR Panel

10.1 Constituent agencies of the Safer Barnsley Partnership should provide evidence and assurance to the partnership that patients/clients are afforded privacy during some appointments in order to facilitate the use of routine enquiry and give patients/clients the opportunity to discuss safety issues.

10.2 The Safer Barnsley Partnership should refresh its training and communication strategy to ensure that information is available to professionals and the public around non-physical indicators of domestic abuse.

10.3 Agencies in Barnsley should provide the Safer Barnsley Partnership with assurance that they have a policy in place to ensure that professionals can be afforded privacy whilst accessing appropriate services.

10.4 The Safer Barnsley Partnership should consider how it can communicate to professionals working within its area, that services are available to them and can be accessed with an expectation of privacy.

10.5 That health agencies who contributed to this review, provide evidence to Safer Barnsley Partnership on how they are addressing the learning identified during the completion of this review in relation to the identification of domestic abuse during contact with patients. This could be achieved by the submission of a report detailing the actions and timescales to embed this learning into practice. It is recommended that the report includes statistical data to evidence the impact of the changes that are made.

10.6 All single agency recommendations are shown in the DHR action plan

Appendix A: Action Plans

No.	DHR Review Recommendation	Scope local or regional	Reviewers recommended action to take	Key actions	Lead agency	Completion deadline
1	That health agencies who contributed to this review, provide evidence to Safer Barnsley Partnership on how they are addressing the learning identified during the completion of this review, in relation to the identification of domestic abuse during contact with patients. This could be achieved by the submission of a report detailing the actions and timescales to embed this learning into practice. It is recommended that the report includes statistical data to evidence the impact	Local	Take a report on both reviews including action plans to the Safer Barnsley Partnership Board and Domestic Abuse Partnership to embed learning into practice. This will also ensure partners clearly evidence activity taken in response to this review through providing an additional level of accountability.	1.1 Development and implementation of action plans by Barnsley Hospital NHS Foundation Trust and NHS South Yorkshire Integrated Care Board.	Barnsley Council, Barnsley Hospital NHS Foundation Trust and NHS South Yorkshire Integrated Care Board.	15 December 2023.
				1.2 DHR reports and recommendations submitted to the Safer Barnsley Partnership Board and Domestic Abuse Partnership.	Barnsley Council	27 June 2024
				1.3 Submit reports to Home Office	Barnsley Council	15 March 2025

	of the changes that are made.			1.4. Submit further report to Domestic Abuse Partnership and Safer Barnsley Partnership Board which will include: progress/completion of actions and outcomes including statistical evidence.	Barnsley Council and partners	12 November 2024
2	That Safer Barnsley Partnership disseminates the learning on this case around the recognition and impact on individuals who are undertaking a caring role, including how support can be accessed.	Local	Improve information dissemination, awareness raising and communications campaigns to target harder to reach groups such as informal carers and elderly people. Such as through regular targeted events.	2.1 Establish a communications and campaigns plan for 2024/25 including generic communications, communications targeted at specific services and groups (including informal carers, AGE UK Barnsley) and hold in person events across the borough.	Barnsley Council, IDAS and partners	01 December 2024
				2.2 Review Domestic Abuse traning package and evaluate training delivered to a) identify any gaps in training, quality of training and impact of training.	IDAS and Barnsley Council	05 September 2024
				2.3 IDAS to deliver bespoke training/awareness raising with Barnsley's Carers Service (Cloverleaf) and develop referral pathways between the two agencies.	IDAS	31 September 2024

				2.4 Update Domestic Abuse Strategy webpage to ensure relevant information and advice is available, including what support is available and how to access this.	Barnsley Council	31 December 2024
				2.5 Multi-agency learning from reviews event to be held in Safeguarding Awareness Week 2024. This will cover learning from Domestic Homicide Reviews, Safeguarding Adult Reviews, Drug Related Deaths Review, Suicide Reviews and highlighting common themes.	Barnsley Council	21 November 2024
3	The Safer Barnsley Partnership should refresh its training offer and communication strategy to ensure that information is available to professionals and the public around non-physical indicators of domestic abuse.	Local	Comprehensive training programme commissioned for professionals across the borough that will also include invitations to NHS partners.	See actions 2.1, 2.2, 2.3 above	Barnsley Council, IDAS and partners	See actions 2.1, 2.2, 2.3 above

4	Agencies in Barnsley should provide the Safer Barnsley Partnership with assurance that they have a policy in place to ensure that professionals can be afforded privacy whilst accessing appropriate services.	Local	Table an item proposal to the Domestic Abuse Partnership.	4.1.All agencies to provide evidence of partner offer to staff seeking help and support via HR support stategies/policies.	All DAP and SBPB member agencies.	31 January 2025
				4.2. BMBC commissioners to meet with HR partner to discuss domestic abuse policy and support for employees.	Barnsley Council	01 September 2024
				4.3 Commissioners across South Yorkshire to work together to develop an out of area support process/protocol for domestic abuse providers to follow.	Barnsley Council	28 February 2025
				4.3 Communications to managers across services that out of area support can be arranged.	Barnsley Council	See above

5	The Safer Barnsley Partnership should consider how it can communicate to professionals working within its area, that services are available to them and can be accessed with an expectation of privacy.	Local	Full communication action plan rolled out across 2024	5.1.Key corporate buildings and partner agencies as well as transport networks shared into distribution of domestic abuse agency advert stickers and bus art showing contact details and pathway.	Barnsley Council and partners	30 August 2024
				5.2. See actions 2.1, 2.4 and actions in section 4 above.	Barnsley Council and partners	31 August 2024
6	That health agencies who contributed to this review, provide evidence to Safer Barnsley Partnership on how they are addressing the learning identified during the completion of this review in relation to the identification of domestic abuse during contact with	Local	Agree with the Domestic Abuse Partnership the format for recording and reporting framework.	6.1. Develop framework with partners for reporting progress against single agency DHR actions, this should include recommendation 3.	Barnsley Council	04 February 2025

	patients. This could be achieved by the submission of a report detailing the actions and timescales to embed this learning into practice. It is recommended that the report includes statistical data to evidence the impact of the changes that are made.			6.2. Submit report detailing progress against actions and changes implemented to working practices to ensure learning is embedded. This should include statistical data/evidence.	Barnsley Council. All key partners to provide relevant information/statistics.	04 February 2025
7	Barnsley Hospital NHS Foundation Trust to provide assurance that patients attending outpatient appointments are asked if they feel safe at home.	Local	Implement process of routine questioning of all patients attending outpatient departments including ophthalmology	7.1. Develop and implement a process to ensure the routine questioning of all patients attending outpatient departments including ophthalmology.	Barnsley Hospital NHS Foundation Trust	Ongoing until March 2025.

8	Ensure all staff receive, and are up to date with, regular adult safeguarding training.	Local	Ensure all staff receive, and are up to date with regular adult safeguarding training.	8.1 Identify staff training needs in relation to adult safeguarding. 8.2. Ensure staff have undertaken and are up to date with the latest safeguarding training, including refresher training.	NHS South Yorkshire Integrated Care Board – Barnsley (GP Practice)	There is no specific completion date. The safeguarding training is a mandatory training requirement and therefore this is on-going.