For Publication

Safer Barnsley Partnership

DOMESTIC HOMICIDE REVIEW

'Karen'

Date of death: May 2022

OVERVIEW REPORT – FINAL VERSION

March 2025

Chair and Author: Carol Ellwood-Clarke QPM
Support to Chair and Author: Ged McManus

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Family Tribute

'My mum was an amazing person, she was kind, funny, hardworking, and extremely generous and thoughtful. She was a wonderful mum and completely selfless with me and my sister, she always made sure we had everything we needed and went above and beyond for us all our lives, she was my best friend. We used to have many fun days out together, lots of laughs, and a shared love for our dogs. She is painfully missed by us and everyone else in her life. She has left a void that can never be filled'.

INTRODUCTION

1.1 The Review Panel offers its sincere condolences to Karen's family.

1.2 This report of a Domestic Homicide Review (DHR) examines how agencies responded to, and supported, Karen, a resident of Barnsley, prior to her murder in May 2022. The review follows the principles within the Home Office Domestic Homicide Review statutory guidance (2016)[1].

1.3 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse, whether support was accessed within the community, and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.4 Karen was married to Jim. They had been in a relationship for 36 years and had two adult children. In May 2022, Jim called the emergency services and reported that he had stabbed Karen. Karen was found at the family home, unconscious, with multiple stab wounds. Karen was later pronounced deceased. Jim was found to have stab wounds; these were self-inflicted. A Home Office post-mortem determined that Karen died as a result of multiple stab wounds.

1.5 Jim was arrested and charged with the murder of Karen. In July 2022, Jim pleaded guilty to the murder of Karen and was sentenced to life imprisonment, with a minimum term of 12 years and six months.

1.6 In sentencing Jim, the Judge stated: 'The backdrop to this case is extraordinarily sad. I have little doubt that you once loved your wife and it appears you brought up your children effectively and well. It was a loving family. But arguments erupted. This, particularly, became bad during the pandemic. The situation between the two of you became worse when you both drank drinks. Each said nasty things about the other and you descended into a vortex of destruction which ended in the murder of your wife. On (redacted) against the backdrop that I have just set out you were drinking, you were arguing and eventually you snapped. You picked up a knife and brutally stabbed your wife. Thereafter you stabbed yourself in an outpouring of self-pity'.

1.7 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic

[1] www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.8 It is not the purpose of this DHR to enquire into how Karen died: this is determined through other processes.

2. TIMESCALES

2.1 On 23 May 2022, South Yorkshire Police notified Safer Barnsley Partnership of the murder of Karen. A meeting was held by Safer Barnsley Partnership, attended by statutory and voluntary agencies on 21 July 2022, where it was agreed to conduct a Domestic Homicide Review. On 11 January 2023, the Home Office was notified of the decision.

2.2 There was a delay in the review commencing due to the criminal investigation taking place. The delay in notifying the Home Office was an administrative oversight and did not affect the commissioning of the review.

2.3 The first meeting of the Review Panel took place on 5 January 2023. The first and subsequent panel meetings were held virtually – contact was maintained with the panel via email and telephone calls. In total, the panel met four times.

2.4 The DHR covers the period from 1 January 2020 to 22 May 2022. The start date was chosen to capture relevant information in the two years prior to Karen's murder, including the timeframe during the Covid-19 pandemic. All agencies were asked to consider and analyse any significant contacts prior to these dates, and this has been included within the review where relevant.

2.5 The Domestic Homicide Review was presented to Safer Barnsley Partnership on 11 April 2024, and concluded on 27 June 2024, when it was sent to the Home Office.

3. CONFIDENTIALITY

3.1 Until the report is published, it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim

and perpetrator: these were identified by the panel and agreed by the victim's family.

3.3 This table shows the age and ethnicity of the subjects of the review. No other key individuals were identified as being relevant for the review.

Name	Relationship	Age	Ethnicity
Karen	Victim	53	White British female
Jim	Perpetrator	54	White British male

4. TERMS OF REFERENCE

4.1 The Review Panel settled on the following Terms of Reference at its first panel meeting on 5 January 2023.

4.2 **The purpose of a DHR is to**:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local Professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7)

4.3 **Specific Terms**

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

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

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

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

5. What knowledge did your agency have regarding any substance/alcohol misuse, and what was the response?

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 Karen and/or Jim, 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 Karen was in an abusive relationship, and did they know what to do with that knowledge?

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

11. What learning has emerged for your agency, and how will this be addressed?

12. Does this learning appear in other Domestic Homicide Reviews commissioned by Safer Barnsley Partnership Board Partnership?

5. METHOD

5.1 On 5 September 2022, Carol Ellwood-Clarke was appointed as the Independent Chair and Author for the review. She was supported in her role by Ged McManus. There was a delay in the review starting, due to the availability of the Chair.

5.2 The first meeting of the Review 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: the other agencies were asked to produce short reports. The Chair provided training to Individual Management Review (IMR)[2] authors, to assist in the completion of the written reports.

5.3 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material produced, was distributed to panel members and used to inform their deliberations. During these deliberations, additional queries were identified, and auxiliary information was sought.

5.4 The Chair liaised with the panel members to identify family members or friends to help inform the DHR process. The police provided access to summaries of statements and information gathered during the homicide investigation. Engagement with family and friends is covered within Section 6.

5.5 The Chair liaised with agencies who had provided palliative care to Karen's mother in September 2020. Karen's mother resided with Karen and Jim at this time. This approach was undertaken to gather any relevant information to inform the review regarding the home circumstances during this time, including engagement with Karen and Jim. The primary care records for Karen's mother were archived. There was no relevant information held within hospital and discharge records. The Chair spoke to a senior manager from the domiciliary care provider that had been attending Karen's home address (daily) to provide palliative care. The senior manager had reviewed the case files and spoken to a main carer to

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

identify any relevant information. There was no such information or concerns identified during this time period.

5.6 The Chair wrote to Jim to inform him of the review. The letter was delivered by Jim's Prison Offender Manager (POM). Jim agreed to contribute to the review. The Chair visited Jim, in the presence of this Prison Offender Manager. Information from this visit is captured in the report where relevant.

5.7 Thereafter, a draft overview report was produced that was discussed and refined at panel meetings before being agreed. The draft report was shared with Karen's family, who were invited to make any additional contributions or corrections.

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS, AND THE WIDER COMMUNITY

6.1 The Chair of the review wrote to Karen's eldest daughter (Daughter 1). The letter included the Home Office DHR leaflet for families. The letter and DHR process were explained to Daughter 1 by a Victim Support Homicide Worker. Daughter 1 initially declined to contribute to the review but agreed for information and updates on the review progress to be provided to her Victim Support Homicide Worker.

6.2 Towards the end of the review, Daughter 1 agreed to contribute to the review, and the Chair met with Daughter 1. Information from this meeting has been included in the report where relevant.

6.3 The Chair of the review was advised by the Victim Support Homicide Worker that due to personal matters, Karen's youngest daughter, (Daughter 2) did not feel able to contribute to the review and agreed for information and progress to be provided to her through her elder sibling and the Victim Support Homicide Worker.

6.4 The Chair of the review wrote to Karen's brother to inform him of the review and invited him to contribute. The letter included the Home Office leaflet for families. Karen's brother declined to speak with the Chair.

6.5 The police provided a summary of statements that had been obtained during the criminal investigation from family members, neighbours, work colleagues, and the wider community. Relevant information from these statements has been included in the report where relevant. A summary of those statements is provided below.

Daughter 1

6.6 Daughter 1 had a good relationship with her mother, Karen. Daughter 1 described Karen as being kind and would do anything for anybody.

Daughter 1 stated that Jim was a good dad, really involved, and that he really cared about his daughters. Daughter 1 described that, at times, Jim would become irate and could not let things drop. He was isolated from people, and he did not like to socialise.

Daughter 1 stated that her parents had a 'horrible relationship', which she explained was due to arguing. Daughter 1 expanded this statement. She stated that if her parents had not been getting on, they would argue, which would then get 'heated' when they had both been drinking alcohol. Daughter 1 described how Karen and Jim consumed alcohol on a nearly daily basis, which had increased over the two years prior to Karen's murder. Daughter 1 stated that just prior to her murder, Karen had had a period of three weeks when she did not drink any alcohol.

Daughter 1 explained that Karen and Jim would argue over something stupid, and this would then get blown up out of proportion and result in shouting, swearing, and banging. The arguing would end when Karen went into another room or fell asleep; however, Daughter 1 explained that Jim would not let the argument end, and he would go back to Karen and carry on. Daughter 1 stated that, at times, she would ask Jim to be quiet because she did not want to listen to the arguing. Daughter 1 stated that during these arguments, she would hear Jim calling Karen's mother (deceased) an 'evil witch' and would say that Karen was turning into her mother: this would then result in Karen calling Jim's mother names, and they would start arguing again.

Daughter 1 stated that she had never known Jim be violent towards Karen until an incident at Christmas 2021. This incident resulted in Jim assaulting Karen. Daughter 1 described another incident, during a family meal in February 2022, when during an argument between Karen and Jim in a restaurant, Karen assaulted Jim. Details of these incidents are captured in Section 13.

Daughter 2

6.7 In her statement to the police, when asked to describe her relationship with her mother, Daughter 2 stated: 'I love her, I love her so much, she

loves me, she told me, she's like said night, love you, all time and I'd say it back to her'. Daughter 2 stated that, deep down, Karen really cared and wanted the best for her.

Daughter 2 stated that she and her sibling were brought up in an environment where it was 'normal' for their parents, Karen and Jim, to argue, and that these arguments tended to increase when both Karen and Jim had been drinking. Daughter 2 described how they (Karen and Jim) lived 'in this delusion that they cannot split up, they cannot sell this house because they love each other, but at same time when as soon as the alcohol came out, they despised each other'.

Daughter 2 stated that the arguments often focused on petty things and deceased family members and whose was best, and that after the arguments, usually the following day, their relationship was back to normal, with no arguing, etc. Daughter 2 described that due to 'lockdown' and all four of them living in the same house, the arguments increased.

Daughter 2 provided details of Karen being assaulted at Christmas 2021 and an incident at a birthday party in February 2022. Further details of these incidents are captured in Section 13.

Friend 1

6.8 Friend 1 was Karen's best friend: having known her since Karen was 17 years old. Friend 1 had known Jim since school. Jim was a friend of Friend 1's previous partner, and in the early years of their friendship, they would often go out together as 'couples' but also in other larger social settings. Friend 1 was a bridesmaid at Karen and Jim's wedding and godmother to Karen's children. After Friend 1's relationship with her partner ended, Friend 1 stated that Jim lost contact with his friends and appeared to become isolated.

Friend 1 described an incident in December 2021, when they saw Karen with bruising. These events are detailed in Section 13.

Friend 1 stated that they had never seen Jim be violent towards Karen. Friend 1 stated that Karen never spoke to her about Jim either hitting her or anything wrong about their relationship.

Friend 2

6.9 Friend 2 met Karen in 1986, when they both worked for the same organisation, and they quickly became friends. Karen was in a relationship with Jim at this time, and Friend 2 later attended their wedding. Friend 2 described how they would socialise on work's dos – often going out about once a month, but never as 'couples'. Friend 2 described Karen as a lovely person, always happy, and never seemed to have anything on her mind.

Friend 3

6.10 Friend 3 had known Karen for over 30 years, having met through work. Friend 3 described Karen as extremely conscientious, her work was of an excellent standard, and she was fun with a great sense of humour. Friend 3 attended Karen and Jim's wedding and thought that they were happy together. Friend 3 stated that Karen never gave them any reason to doubt this, and that they were a 'normal' couple.

Friend 3 stated that they socialised outside of work with Karen on work's dos, but also outside of these through their friendship: they visited restaurants and went to the theatre.

Friend 4

6.11 Friend 4 was in a relationship with Daughter 1 and had known Karen and Jim for eight months. Friend 4 would visit Karen and Jim's house at least 2 to 3 times a week. Friend 4 described Karen and Jim's relationship as 'hit and miss': in that one minute it was good, and the next it was not so good. Friend 4 described how they had never seen any physical violence, or been made aware of any physical violence, but that they had heard raised voices from Karen and Jim: these were described as verbal arguments and that these arguments were happening weekly. Friend 4 stated that there was 'an equal split' between Karen and Jim as to who, in their opinion, was the instigator to those arguments. Friend 4 stated that you would never have said one was worse than the other. Friend 4 described in the 2 to 3 months prior to Karen's murder, that the arguments appeared to have settled down.

Neighbour 1

6.12 Neighbour 1 has known Karen and Jim for over 20 years. They described them as a very normal, typical family and good neighbours, and they would talk to Jim and Karen over the fence. Jim and Karen were described as private people, with Karen being more outgoing. An example of which, was that Karen would pass ice pops and sweets over the fence to

Neighbour 1's grandchildren when they visited. Neighbour 1 stated that Karen and Jim would spend 2 or 3 evenings a week in their front garden, which is where they tended to sit and have barbeques if the weather permitted. Neighbour 1 recalled that as part of the VE celebrations during the Covid-19 pandemic, there was a street party, and that Jim and Karen provided the music for all to enjoy. Neighbour1 stated that they have never seen either of them drunk during all the time they have been neighbours.

Neighbour 2

6.13 Neighbour 2 has known Karen and Jim for over 20 years. Neighbour 2 described Karen and Jim as 'pleasant'; however, their conversations with Jim were limited to work and football. Jim was described as a 'bit of a loner'. Neighbour 2 stated that they never knew of any marital discord, and whilst they had heard the odd raised voice, this was not threatening.

Employer

6.14 The Chair spoke to Karen's manager, who provided information and a report in relation to Karen's employment and the support provided by her employer due to Karen's ill health and during the Covid-19 pandemic. Karen's colleagues, school contacts, and contractors, described her as an organised, effective, and respected member of the team. Karen was proactive and responsible, and there were no poor performance issues. Further information has been captured within the report where necessary.

6.15 Karen's line manager agreed to speak with Karen's work colleagues to inform them of the review and establish if they wished to speak with the Chair. The Chair provided a letter for the work colleagues as a means of introduction, which also included information about the review process and a Home Office leaflet for employees and colleagues. The Chair was informed by Karen's line manager that the letter had been delivered; however, colleagues were still coming to terms with the murder of Karen and declined to be involved in the review, as they found the prospect too upsetting.

7. CONTRIBUTORS TO THE REVIEW

7.1 This table show the agencies who provided information to the review.

Agency	IMR	Chronology

Barnsley Hospital NHS Foundation Trust	✓	✓
NHS South Yorkshire Integrated Care Board – Barnsley (GP Practice)	✓	✓
South West Yorkshire Partnership NHS Foundation Trust	✓	✓
South Yorkshire Police	✓	✓
Yorkshire Ambulance Service NHS Trust		✓

7.2 The IMRs contained a declaration of independence by their authors, and the style and content of the material indicated an open and self-analytical approach, together with a willingness to learn. All the authors explained that they had no management of the case or direct managerial responsibility for the staff involved with this case.

7.3 The following agencies were written to as part of the review process, but held no information:

- Adult Social Services
- Berneslai Homes[3]
- Humankind[4]
- Independent Domestic Abuse Service
- Safer Neighbourhood Services

7.4 Below is a summary of contributors to the review:

7.4.1 **Barnsley Hospital NHS Foundation Trust**

Barnsley Hospital is managed by our Board of Directors. The Board is responsible for the operational management of the hospital and, with input from the Council of Governors, sets the direction for the future of the hospital.

7.4.2 **NHS South Yorkshire Integrated Care Board – Barnsley (GP Practice)**

NHS South Yorkshire Integrated Care Board – Barnsley (sometimes shortened to ICB), represents 32 GP practices and over 245,000 patients, and is based in South Yorkshire. We have responsibility for commissioning healthcare for the population of Barnsley. Commissioning is a process of planning and buying services to ensure that the people who live in the borough have the right healthcare.

[3] Berneslai Homes is Barnsley Metropolitan Borough Council's housing company responsible for managing 18,500 homes on their behalf.

[4] https://humankindcharity.org.uk/service/barnsley-recovery-steps/ The commissioned service for substance misuse and low-level mental health.

7.4.3 **GP Practice**

The GP practice has two locations. Between these sites, the practice has approximately 18,000 patients across the practice areas. One of the GP practices is a training practice, offering training and mentoring to future general practitioners. This GP practice is a PMS practice[5], with a large team of clinicians and administrative staff. Delivering high quality health care in line with our core and additional contracts, as part of the primary care function.

7.4.4 **South West Yorkshire Partnership NHS Foundation Trust**

We exist to help people reach their potential and live well in their communities. We do this through our mental health, community, learning disability and wellbeing services across Barnsley, Calderdale, Kirklees, and Wakefield. We also provide specialist secure mental health (forensic) services for the whole of Yorkshire and Humber.

7.4.5 **South Yorkshire Police**

South Yorkshire Police is the territorial police force responsible for policing South Yorkshire in England.

7.4.6 **Yorkshire Ambulance Service (YAS)**

YAS covers nearly 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline, and inner cities. YAS serves a population of over five million people across Yorkshire and the Humber and strives to ensure that patients receive the right response to their care needs as quickly as possible, wherever they live. YAS employs more than 5,800 staff, who together with over 1,100 volunteers, provides a vital 24-hour, seven-days-a-week, emergency and healthcare service.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the Review Panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Fiona Bankes	Practice Manager	GP Practice
Alice Barker-Milner	Policy Officer – Domestic Abuse	Barnsley Metropolitan Borough Council,

[5] Personal Medical Services (PMS) is a voluntary option for GPs and other NHS staff to enter into locally negotiated contracts. The scheme applies to GP Practices in England only. The key aims of PMS are to: provide greater freedom to deal with the primary care needs of patients.

		Healthier Communities
Donna Clark	Hub and Helpline Manager	Independent Domestic Abuse Services (IDAS)
Rosemary Clewer	Senior Commissioning Manager	Stronger, Safer & Healthier Communities Business Unit, Barnsley Metropolitan Borough Council
Emma Cox	Associate Director of Nursing, Quality and Professions	South West Yorkshire Partnership NHS Foundation Trust
Carol Ellwood-Clarke	Independent Chair and Author	
Catherine Holliday	Named Professional for Safeguarding	Yorkshire Ambulance Service
Amy Hoyle	Contracts and Relationship Officer – Domestic Abuse	Barnsley Metropolitan Borough Council
Calise Martin	Case Review and Policy Officer	South Yorkshire Police
Claire McEvoy	Area Manager for Barnsley Recovery Steps	Humankind
Ged McManus	Support to Chair and Author	
Gillian Pepper	Adult Safeguarding Nurse Specialist	NHS Integrated Care Board – Barnsley
Rebecca Slaytor	Named Nurse for Adult Safeguarding	Barnsley Hospital NHS Foundation Trust

8.2 The Chair of Safer Barnsley Partnership was satisfied that the Review Panel Chair and Author were independent. In turn, the Review Panel Chair believed that there was sufficient independence and expertise on the panel to safely, and impartially, examine the events and prepare an unbiased report.

8.3 The Review Panel met four times, and the circumstances of Karen's murder were considered in detail, with matters freely and robustly considered to ensure all possible learning could be obtained. Panel meetings were held

virtually. Outside of the meetings, the Chair's queries were answered promptly, via email or telephone call, and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

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

9.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair and Author. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – not South Yorkshire), 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[6].

9.3 Carol was supported in her role by Ged McManus. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. 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. Prior to leaving the police service in 2016, he was a Superintendent, with particular responsibility for partnerships, including Community Safety Partnership and Safeguarding Boards.

9.4 Between them, they have undertaken the following types of reviews: child serious case reviews; Safeguarding Adults 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 both completed accredited training for DHR Chairs, provided by AAFDA.

[6] https://safelives.org.uk/

9.5 Both have previously completed DHRs within Barnsley.

10. PARALLEL REVIEWS

10.1 HM Coroner for Barnsley opened and adjourned an inquest. Following the conclusion of the criminal trial and conviction of Jim, the inquest was closed.

10.2 South Yorkshire Police completed a criminal investigation following Karen's murder. In July 2022, Jim pleaded guilty to the murder of Karen and was sentenced to life imprisonment, with a minimum term of 12 years and six months.

10.3 The review was not aware of any other investigations that have taken place since Karen's murder.

11. EQUALITY AND DIVERSITY

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

- **age** [for example an age group would include "over fifties" or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil

partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].

- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[7]

11.3 There is nothing in agency records that indicated that any subjects of the review lacked capacity[8], in accordance with the Mental Capacity Act 2005. Professionals applied the principle of the Mental Capacity Act 2005:

[7] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

[8] The Mental Capacity Act 2005 established the following principles:
Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".
Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".
Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".
Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.

'A person must be assumed to have capacity unless it is established that he lacks capacity'.

11.4 Karen had been diagnosed with pneumonitis[9], and then in September 2019, she was diagnosed with fibrosis[10], and she was under the care of respiratory specialists. Karen had also been referred for physiotherapy due to hip and leg pain caused by sciatica.

11.5 Karen was supported by her employer in relation to her ill health, and reasonable adjustments were made in accordance with occupational health reports, including arrangements to work wholly at home and avoid onsite meetings. Regular contact with Karen was in place with her line manager and the team – both through scheduled team meetings, weekly catch ups, and ad hoc calls. Karen had access to Microsoft Teams, had a mobile phone to undertake her role, and she worked flexibly. At the start of the Covid-19 pandemic, due to Karen's immune system, she was classed as being 'vulnerable'[11] and at a higher risk of serious illness if she became infected with Coronavirus.

11.6 Karen was in full time employment. Whilst adaptations were made to allow her to continue to work due to her respiratory issues, she was not classed as being disabled; therefore, she was able to lead a normal life and complete daily tasks, both at work and within the home environment.

11.7 During the timescales of the review, Jim had limited contact with a GP – for routine health matters and annual asthma reviews.

11.8 All subjects of the review are white British nationals. English is their first language.

11.9 The number of domestic abuse crimes recorded by the police in England and Wales in the year ending March 2021, increased by 6% – from

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Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".
Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".
[Mental Capacity Act Guidance, Social Care Institute for Excellence]

[9] This occurs when the body's immune system overreacts with repeated exposure to allergens that can cause pulmonary fibrosis, which is essentially lung scarring.

[10] https://www.nhs.uk/conditions/idiopathic-pulmonary-fibrosis/

[11] https://www.gov.uk/government/publications/covid-19-guidance-for-people-whose-immune-system-means-they-are-at-higher-risk

798,607 (in the year ending March 2020) to 845,734[12]. This continues the trend of increases seen over previous years.

11.10 Domestic homicide and particularly domestic abuse, are predominantly a crime affecting women, with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. In November 2022, the Office for National Statistics published the 'Domestic abuse in England and Wales overview'.[13] The following data was recorded:

- 'The Crime Survey for England and Wales (CSEW) estimated that 5.0% of adults (6.9% women and 3.0% men) aged 16 years and over experienced domestic abuse in the year ending March 2022; this equates to an estimated 2.4 million adults (1.7 million women and 699,000 men).
- 'Approximately 1 in 5 adults aged 16 years and over (10.4 million) had experienced domestic abuse since the age of 16 years.
- 'There was no significant change in the prevalence of domestic abuse experienced by adults aged 16 to 59 years in the last year, compared with the year ending March 2020; a year largely unaffected by the coronavirus (COVID-19) pandemic and the last time the data were collected.
- 'The number of police recorded domestic abuse-related crimes in England and Wales increased by 7.7% compared with the previous year, to 910,980 in the year ending March 2022; this follows increases seen in previous years and may reflect increased reporting by victims.
- 'The Crown Prosecution Service (CPS) domestic abuse-related charging rate in England and Wales increased for the first time in four years to 72.7% in the year ending March 2022 but remains below the year ending March 2018 (75.9%).
- 'The National Domestic Abuse Helpline delivered 50,791 support sessions through phone call or live chat in the year ending March 2022, a similar number to the previous year'.

12. DISEMMINATION

12.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

12 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2021

13 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2022

- The family
- Safer Barnsley Partnership
- All agencies that contributed to the review
- South Yorkshire Police and Crime Commissioner
- Domestic Abuse Commissioner

13. BACKGROUND, CHRONOLOGY AND OVERVIEW

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the subjects of the review and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies, and material gathered by the police during their investigations.

The below section contains information gathered from Jim during contact with the Chair and has been included in this section to provide context to the review. The Review Panel acknowledges that some of these comments can be seen as victim blaming but have included them within this section, highlighting that these are the views of Jim and not of the Review Panel.

13.1 Karen

13.1.1 Karen was brought up in Barnsley by both parents: together with her brother. As an adult, Karen did not have much contact with her brother, until after the death of their mother, when Daughter 1 stated that they became close, especially in the last year of Karen's life.

13.1.2 Karen enjoyed socialising, shopping, walking her dogs, and spending time with her daughters. Daughter 1 stated that growing up, they had nice family holidays, and was complimentary about the way that her parents had treated her and her sibling, and she considered that she had a good and happy childhood.

13.1.3 Jim told the Chair that Karen was a lovely mum who was kind to their children and dealt with most of the day-to-day matters in life, and that Karen was very good at dealing with practical things.

13.1.4 Jim told the Chair that Karen had a high-pressure job that she was very good at. Jim also stated that Karen was sometimes obsessive about work and gave an example that when she was not working, Karen would be thinking about work during her social time, and Jim stated that this sometimes caused tension.

13.2 Jim

13.2.1 Jim was a self-employed painter and decorator. Jim told the Chair that he mainly worked on high-end properties, which sometimes meant that there was a lot of pressure on him to get the quality and timeliness of the work right. Neighbours stated that Jim was meticulous and very proud of his work.

13.2.2 Daughter 1 told the Chair about Jim's mental health and spoke about an incident when she was around 12 years old, when she found her father in the garage with a rope, which he was potentially going to use to try to self-harm. Daughter 1 spoke about a further incident when she was about 17 years old, when she interrupted him when he was about to take an overdose.

13.2.3 Daughter 1 described how her father, Jim, was isolated, and that he did not have any friends outside of the house. Daughter 1 stated that he had gradually stopped seeing anyone else over the years, and that he could be quite difficult and would not easily get on with other people.

13.2.4 Friend 1 described Jim as a passionate man, and that Karen and his daughters were his world.

13.2.5 Jim had no previous convictions and was not known to the police or any other agency as a perpetrator.

13.3 Karen and Jim's relationship

13.3.1 Karen and Jim had been in a relationship for 36 years. Daughter 1 stated that Karen and Jim had never been good for each other, since her early childhood. Daughter 1 recalled that her mother and father had always argued for as long as she could remember. Daughter 1 recalled an occasion, as a child, when the family were staying in a caravan in France and the police were called as result of an argument between Karen and Jim.

13.3.2 Daughter 1 described how during the Covid-19 pandemic, Karen was working from home, and Jim did not work for a 3-month period: this resulted in them spending a lot of time together in the house, and it appeared as if they were 'on top' of each other. Daughter 1 stated that during this time, Jim shut himself away from everyone and did not socialise.

13.3.3 Daughter 1 and 2 described how Karen and Jim would drink alcohol every day, usually on an evening after they had both finished work. Daughter 1 stated that in the couple of years before Karen's murder, Karen and Jim's alcohol consumption increased, and she would at times find bottles of alcohol in cupboards, as if they had been hidden. Daughter 1 stated that

although her parents consumed alcohol, she would not describe them as alcoholics or alcohol dependent.

13.3.4 Daughter 1 stated that arguments would start over a small thing but would quickly escalate, with reference continually being made to old issues. Daughter 1 described how Jim would not stop and would continue ranting – sometimes even to himself. Daughter 1 stated that the arguments were worse when her parents had been drinking and could be about anything. Daughter 1 recalled one argument about pebbles in a fish tank. Daughter 1 described that whilst both Karen and Jim said horrible things to each other, it was Jim who would become fixated on something and not let it go – continuing the argument.

13.3.5 Jim told the Chair that he and Karen had a drinking culture, and that they would drink every day. Jim stated that he would sometimes have periods of abstinence, but Karen would not join in with this. Jim stated that he had asked Karen to reduce her drinking because of the large amount of medication she was taking, but Karen did not do so.

13.3.6 Jim stated that they would often argue over small matters, especially when they had been drinking. Jim blamed the arguing on Karen and stated that she would find an issue and keep going until he argued back; however, the next day they would pick up things again as if nothing had happened. The Review Panel acknowledged that the views of Jim contradicted those of the family and felt that this was victim blaming. Nonetheless, these views have been included as context for the review.

13.3.7 Jim stated that there had never been any physical violence in their relationship until an incident in December 2021, when he assaulted Karen. This is covered further on in this section.

13.4 Events prior to the timescales of the review

13.4.1 On 29 December 2019, Karen contacted the police to report that one of her dogs had been attacked by another dog whilst she had been out walking them.

13.5 2020

13.5.1 On 13 January, Karen had a telephone consultation with a GP. The consultation discussed Karen's ongoing treatment by respiratory specialists. Karen was issued with a fit note[14] for six weeks.

13.5.2 On 6 February, Karen attended a respiratory appointment. Karen reported feeling depressed and was prescribed antidepressants. A letter was sent to

[14] https://www.gov.uk/government/collections/fit-note

Karen's GP to inform them of the prescribed medication. Over the following months, Karen continued to have frequent contact with the respiratory clinic.

13.5.3 On 13 February, Jim was seen by a practice nurse for an annual asthma review. Jim stated that he was drinking around 15 units of alcohol per week. There was no evidence of hazardous drinking.

13.5.4 On 3 April, Karen was advised by a GP to 'shield' for 12 weeks, in accordance with Government guidelines put in place due to the Covid-19 pandemic.

13.5.5 At the end of August, Karen's mother was discharged from hospital and moved into Karen and Jim's home, where she received palliative care. Jim told the Chair that Karen's mother was unable to go home due to the state of disrepair of her home. Furthermore, there was no place at a hospice, which was why she came to live with them. During that time, many professionals were visiting the house to provide support and palliative care.

13.5.6 On 7 September, it was documented that Karen had been diagnosed with pneumonitis, following a bronchoscopy and CT chest scan.

13.5.7 On 10 September, Karen had a telephone consultation with a GP. Karen requested a referral to an alternative respiratory department in Sheffield. Karen mentioned some stress due to her mother's terminal illness, and that her mother had come to live with the family.

13.5.8 Between September and December, Karen had contact with health professionals in relation to her diagnosed illness. These were routine appointments to respond to her illness. During an appointment on 5 November 2020, it was documented that Karen was consuming 40 – 50 units of alcohol per week. There was no record that Karen had been provided with information or advice in relation to the level of alcohol consumption.

13.6 2021

13.6.1 On 7 July, Jim attended at hospital with a head laceration. No explanation was provided for the injury.

13.6.2 On 24 August, Karen had an annual medical review with a practice nurse. This took place via telephone. It was documented that Karen reported her alcohol intake to be about 10 units a week. Karen scored 0 on the PHQ-9[15] depression screening.

[15] The 9-question Patient Health Questionnaire (PHQ-9) is a diagnostic tool introduced in 2001 to screen adult patients in a primary care setting for the presence and severity of depression.

13.6.3 At the beginning of October, Karen's GP referred her for physiotherapy due to ongoing problems with pain in her leg and hip.

13.6.4 On 7 October, Karen saw a GP due to bruising and swelling to her ankle and knee. Karen was advised to contact radiology for an X-ray, which she did the following day. During the homicide investigation, Friend 1 told the police that the injury had occurred when Karen fell over furniture in the home. Friend 1 provided the police with photographs of the injury, which Karen had sent at the time.

13.6.5 Daughter 1 told the Chair of an occasion prior to Christmas, when Karen and Jim had been having a 'full argument' when a friend called to see Karen. Daughter 1 described how the argument suddenly stopped, and Karen and Jim presented a picture of normality until the friend left: whereupon the argument immediately started. Daughter 1 gave this example to demonstrate how arguments could pause and start quickly.

13.6.6 On 23 December, Karen saw a GP due to a chest injury. Karen stated that that the injury had been caused falling over a Christmas tree in the family home.

The following incident was provided to the police during the homicide investigation.

13.6.7 Friend 1 stated that they had visited Karen and Jim in their home on Christmas Eve. Friend 1 noticed that Karen was struggling to walk. Karen stated that she had fallen over a dog's bowl and landed on the hearth, which had caused an injury to her ribs and bruising under her eyes. Friend 1 stated that she queried with Karen how a fall would cause bruising under the eyes, but Karen did not give a response.

13.6.8 Daughter 1 told the Chair that she had asked Karen about this incident and how she had got black eyes from a fall. Karen told Daughter 1 that Jim had assaulted her by elbowing her.

The following incident was provided to the police during the homicide investigation.

13.6.9 Daughter 1 told the police of an incident that had occurred on Christmas Day night. Daughter 1 stated that she had been in her bedroom with her boyfriend and Daughter 2, when they heard Karen and Jim 'bickering' in their bedroom and then heard Karen scream. Daughter 1 stated that they went into the bedroom, and she saw blood on Karen's face. There was also blood on the pillow. Karen told Daughter 1 that Jim had punched her in the face whilst they were arguing. Daughter 1 described how Jim was crying and that he stated Karen had been sat on top of him, with her hands around his neck, and that was why he hit her. Karen told Daughter 1 that

she had not been sat on him nor had her hands around his throat. This incident was corroborated by Daughter 2. Daughter 1 stated that she left the family home for a few days after this incident.

13.7 2022

13.7.1 At the beginning of the year, Karen contracted Covid-19, which resulted in her having additional contact with health professionals.

13.7.2 At the start of February, Karen was assessed by a physiotherapist. The assessment took place by telephone, and the outcome was for Karen to have further face-to-face appointments. These appointments took place between February and May.

The following incident was provided to the police during the homicide investigation.

13.7.3 On a date in February, Karen and Jim went to a restaurant with Daughter 1 and 2. During the meal, Karen assaulted Jim. Daughter 1 described how the atmosphere between Karen and Jim was tense: Karen had consumed a lot of alcohol, and Jim had told her to stop drinking. At which point, Karen hit Jim. Daughter 1 described this as a 'back handed swipe'. The incident was corroborated by Daughter 2. Jim left the restaurant and went home in a taxi.

13.7.4 On a date in May, Karen was found deceased at her home address. Jim was arrested and later charged with the murder of Karen.

14. ANALYSIS USING THE TERMS OF REFERENCE

14.1 Term 1

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

14.1.1 None of the agencies who provided information to the review, identified any indicators of domestic abuse during their contact with Karen. The review established that there had been no reports of domestic abuse, involving either subject of the review, reported to the police or other agencies.

14.1.2 There were opportunities within the review's timescales for Karen to have been asked directly about domestic abuse and to probe further the

causation and explanation for injuries that she had presented with to health professionals.

14.1.3 Records held by Barnsley NHS Foundation Trust, identified that during Karen and Jim's contact with the Trust, neither were asked directly about domestic abuse. Barnsley Hospital NHS Foundation Trust has a policy for the Management of Domestic Abuse in which it identifies that staff should undertake a routine enquiry for all patients attending, if safe to do so, as part of the clinical/health assessment. The Review Panel was informed that adherence to this policy was not routinely occurring within the outpatient setting, and that within the Emergency Department, staff were expected to make the routine enquiries and document in patients notes if there were any safeguarding concerns. This was identified as a single agency area of learning. The Review Panel heard that a trial had started recently in outpatients whereby patients were asked if they felt safe at home. During April 2023, 770 people were asked if they felt safe at home: six of those people disclosed domestic abuse, with appropriate follow-up action being taken.

14.1.4 South West Yorkshire Partnership NHS Foundation Trust had limited contact with Karen. Karen attended all physiotherapy appointments and was seen alone. Karen had been referred into physiotherapy due to hip and leg pain, and as part of the assessment, she was asked about the cause of the pain. Karen's perception was that this was potentially sciatica. The Review Panel was informed that had Karen disclosed that the cause of pain was traumatic, or had there been concerns around an inconsistent history, this would have led to further enquiries and contact with the Trust Safeguarding Team for further advice and support.

14.1.5 The Review Panel was informed that South West Yorkshire Partnership NHS Foundation Trust had commenced a domestic abuse project that included the development of guidance to support staff with 'routine enquiry', and that the Trust would be rolling out the implementation of 'routine enquiry' from September 2023.

14.1.6 Karen's presentation to health professionals was, in the main, due to her ongoing ill health. Karen had two face-to-face contacts with a GP towards the end of 2021. Both of these contacts were for minor injuries, which Karen stated that she had sustained during a fall within the home. The nature of the injuries and mechanisms described by Karen did not raise any concerns to prompt the GP to ask additional questions around causation and any link to domestic abuse.

14.1.7 The Review Panel was informed that the GP practice had identified learning around additional questioning of patients when potential indicators of

abuse, including increased use of alcohol and/or substance misuse, had been identified. The Review Panel was also informed that meetings were taking place with IDAS to progress this area of learning, which included reviewing existing templates currently used to gather and prompt additional questions on these indicators of abuse. In addition, a training programme is to be offered to all staff within a primary care setting. This will include providing training on recognising, asking about, and managing abuse, and will include the findings of current Domestic Homicide Reviews. All GP practices will be offered the training programme and be encouraged to participate. Upon completion of the training, the GP practice will receive accreditation to become a 'Speak up' premise and will be able to display appropriate publicity to promote the practice as somewhere people can safely discuss abuse. The Review Panel was informed that this will commence in September 2023, with an anticipated 12 – 18 months to complete.

14.1.8 NICE Guidelines[16] – 'Domestic violence and abuse', Quality standard [QS116] (Published: 29 February 2016), states: 'People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion'. The guidelines further document: 'Some people who present to frontline health and social care practitioners have indicators of possible domestic violence or abuse. Services should ensure that they can provide a safe and private environment in which people feel able to disclose that they are experiencing domestic violence and abuse. In some healthcare settings (for example, mental health and drug or alcohol services, and sexual health services), more people will have indicators of possible domestic violence or abuse than in other settings'.

14.1.9 The Review Panel reflected on the above guidelines and acknowledged that Karen was seen alone for most of her contacts with health professionals. At no stage did Karen disclose domestic abuse. Karen was never asked directly as to whether she was experiencing domestic abuse, and there was no indication within her presentation that injuries she had sustained were linked to domestic abuse; therefore, the requirement to ask a routine enquiry within these settings had not been reached in accordance with NICE guidelines.

14.1.10 The Review Panel acknowledged the work that had commenced by health agencies involved in this review, to address identified learning around the use of routine enquiry; however, the Review Panel agreed that those

[16] https://www.nice.org.uk/guidance/qs116/chapter/quality-statement-1-asking-about-domestic-violence-and-abuse

agencies should provide evidence and assurances to Safer Barnsley Partnership on the implementation of this area of learning.

14.1.11 Daughter 1 told the Chair that she had seen her mother with black eyes prior to Christmas, and that her mother told her that these had been caused by Jim. On Christmas Day 2021, Jim assaulted Karen. There is no information held within health records that Karen was seen by any health professional in relation to this assault or injuries sustained. During contact with the Chair, Jim stated that there had been no physical violence within their relationship until the assault on Christmas Day.

14.1.12 Although there were no reports of domestic abuse prior to the murder the Review Panel were aware that many incidents of domestic abuse are not reported and that on average victims experience 50 incidents of abuse before getting effective help[17]. Research conducted by Her Majesty's Inspector of Constabulary (HMIC)[18] found the following reasons for not reporting domestic abuse to the police;

Fear of retaliation (45 percent); embarrassment or shame (40 percent); lack of trust or confidence in the police (30 percent); and the effect on children (30 percent).

14.1.13 In addition, the Victim Support report 'Survivor's Justice'[19] contains the following information:

Barriers to reporting as cited by Victim Support caseworkers

Barriers to reporting	Percentage of respondents citing barrier
Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger	52%
Fear they would not be believed or taken seriously	42%
Fear, dislike or distrust of the police/criminal justice system (CJS)	25%
Concern about their children and/or the involvement of social services	23%

[17] SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives.
[18] https://hmicfrs.justiceinspectorates.gov.uk/publications/improving-the-police-response-to-domestic-abuse/

[19] https://www.victimsupport.org.uk/wp-content/uploads/documents/files/VS_Survivor%E2%80%99s%20justice.pdf

Poor previous experience of police/CJS	22%
Abuse normalised, not understood or believed to be deserved	15%
Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish perpetrator	14%
Cultural or community concerns	9%
Financial concerns	7%
Housing concerns	4%
Embarrassment	3%

14.2 Term 2

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

14.2.1 Jim had one contact with a professional during the timescales of this review. This contact was for an annual health assessment. There were no indicators or evidence within this contact that Jim was a perpetrator of domestic abuse.

14.2.2 During contact with the Chair, Jim stated that there had been a small number of incidents that had occurred during his marriage with Karen: he referred to these as 'big issues' that he had kept stored in a 'grudge bank' inside his memory. One of these incidents related to Karen assaulting Jim in February 2022. The other incidents he told the Chair, related to arguments that he had had with Karen at certain times in his life, one of which occurred on the date of his mother's funeral. The Review Panel acknowledged that the views of Jim, and his use of terminology in referencing his relationship with Karen, were victim blaming; however, they have been included in here for context.

14.2.3 The panel member from IDAS provided the Review Panel with information from IDAS, which explains what is meant by 'victim blaming'. The Review Panel agreed that it was of relevance to be included within this report, to understand and contextualise the information provided by Jim:

Victim blaming occurs when the **victim** of a crime or any wrongful act is held entirely or partially at fault for the harm they were subjected to. Victims of domestic abuse, experience victim blaming in a multitude of ways, through media messaging, individual's responses to disclosures or the way they are treated by institutions and organisations.

Victim blaming is pervasive throughout our society and culture. It is ingrained in gender norms and stereotypes. Countering victim blaming requires us to reframe our thinking and our response. Victim blaming let's perpetrators off the hook and serves to justify their behaviour. It can also act as a form of social control; it suggests that sexual violence and domestic abuse could be prevented if victims follow the rules, or that there are circumstances where abuse and violence are justified.

Victim blaming can include:

- Making comments that blame or shame the victim, such as comments about what they were wearing, how they were behaving, how much they drank or what they did to provoke.
- Investigations making victims feel that they are being put on trial.
- Gender roles and stereotypes that reinforce ideas about sexuality and violence or abuse, such as men needing to have sex or not being able to control sexual urges.
- Myths and stereotypes about the 'perfect victim', some being perceived as being more credible or deserving than others.
- Making victims feel guilty for the potential impact of reporting on the perpetrator, such as the impact of a criminal record.
- Excusing the perpetrators behaviour or reframing it so they are less culpable, such as, 'Dad killed 6 over wife's affair'.
- Minimising the abuse or violence.
- Being disbelieved or disowned by family or friends.
- Expecting a practical solution to have prevented the abuse or violence, such as covering your drink in a bar to prevent spiking, not walking alone at night, dressing 'modestly'.
- Holding the victim responsible for the harm that the perpetrator causes to the children, including putting all the responsibility on the victim for keeping the children safe while doing very little to prevent the perpetrator from causing the harm.
- Seeing coping strategies as justifications for continued abuse or violence, such as alcohol or drug misuse.

The impact of victim blaming is wide reaching:

- Secondary victimisation can occur when the victim suffers harm as a result of the response to the harm caused rather than directly due to the harm.
- Limits reporting and criminal prosecutions.
- Prevents gathering information.
- Creates a lack of trust of professionals and support organisations.

- Allows perpetrators to continue to cause harm with impunity because they are not held to account.
- Reinforces harmful myths and stereotypes.
- Shuts down disclosures.
- Can increase risk of negative mental health impact and suicide.
- Minimises or justifies the abuse.
- Empowers the perpetrator.
- Traps victims in abusive relationships.
- Causes harm to children, including leading to them being taken away from the safe parent.
- Potentially leads to serious incidents and domestic homicides.

14.3 Term 3

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

14.3.1 Agencies were not aware that Karen was a victim of domestic abuse. The Review Panel was informed that had professionals been aware, then they would have been required to complete a DASH[20] (Domestic Abuse, Stalking and Honour Based Abuse) risk assessment. For those agencies working within health, they would also have been able to contact their respective Safeguarding Team for advice.

14.3.2 The Review Panel discussed whether there had been information held by agencies that could have indicated that Karen may have been at an increased risk of domestic abuse. The Review Panel identified that whilst there had been no direct reference in agencies' records that Karen had been a victim of domestic abuse, there had, on reflection during the completion of this review, been an accumulation of events over time that, in hindsight, the Review Panel agreed may have had an impact on Karen's health and wellbeing. These events included:

- Karen's illness and impact on her day-to-day life.
- Working from home arrangements, initially due to Karen's illness and then later the Covid-19 pandemic.
- Discharge of Karen's mother from hospital and subsequent palliative care undertaken in Karen's home.
- Impact of Covid-19 pandemic and increased risk to Karen's health.
- Increased consumption of alcohol.

[20] https://www.dashriskchecklist.co.uk/

14.3.3 The Review Panel reflected on the events and had a detailed discussion as to whether they collectively provided an indicator that Karen was at an increased risk of domestic abuse. The Review Panel concluded that, with hindsight, and looking at the events in their entirety as part of the review, there were indicators that Karen could have been at an increased risk of domestic abuse. In reaching this decision, the Review Panel acknowledged that agencies were not aware, at the time of their involvement, of all the events.

14.3.4 The Review Panel sought information as to whether Karen had been recognised as a 'Carer' for her mother – both prior to and after her discharge from hospital. Information seen by the Review Panel, identified that Karen would often accompany her mother to medical appointments prior to her mother's terminal diagnosis. There was no information held by agencies that Karen had been her mother's 'Carer', and there was no record that a Carer's Assessment had been offered.

14.3.5 The Review Panel was informed that Karen could have been referred to Cloverleaf[21]. This is a free service in Barnsley for unpaid carers. They provide support, advice, and training designed to improve the quality of life and wellbeing of local carers. The team offers information and advice, drop-in support, groups, events and activities, education, benefits, and financial advice and training.

14.3.6 The Review Panel agreed that there was learning for agencies in relation to recognising and responding to the impact on individuals who are taking on the significant care of others and how those individuals can be supported in providing that care. The Review Panel has made a relevant recommendation to address this area of learning.

14.4 Term 4

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

14.4.1 Karen had no attendances to the Emergency Department at Barnsley Hospital NHS Foundation Trust.

14.4.2 Karen was referred into the respiratory team at Barnsley Hospital NHS Foundation Trust in August 2019. Since that time, she had been in receipt

[21] https://cloverleaf-advocacy.co.uk/areas/barnsley

of medical treatment for a long-term condition that affected her lungs and breathing. Karen's last contact was in January 2022.

14.4.3 Jim had one contact with Barnsley Hospital NHS Foundation Trust (in July 2021), when he attended for treatment to a laceration to his head.

14.4.4 All interactions and contact with Karen and Jim by Barnsley Hospital NHS Foundation Trust, were timely, proportionate, and relevant to the health conditions presented. There was no evidence that Karen and Jim were unable to access services when required.

14.4.5 At the time of Karen's referral into physiotherapy services, the Review Panel was informed that there was a national increase in referrals for musculoskeletal problems: this led to an increase in waiting times for physiotherapy services. At that time, all referrals into the physiotherapy service were triaged by a senior physiotherapy clinician (within 48 hours of receipt) to determine urgency. After which, the patient was informed of the outcome of the triage and the date of their first appointment. The GP referral for Karen identified that Karen's referral was routine, which was confirmed through triage, and Karen was offered appropriate treatment thereafter.

14.5 Term 5

What knowledge did your agency have regarding any substance/alcohol misuse, and what was the response?

14.5.1 It is the policy of Barnsley Hospital NHS Foundation Trust to ask patients of their alcohol usage as part of the patient assessment. On 5 November 2020, Karen was discharged from Barnsley Hospital NHS Foundation Trust, following a period of dental treatment. A discharge letter was sent to Karen's GP, which detailed that Karen had stated that she was drinking between 40 – 50 units of alcohol per week. The GP practice had no record of receiving this letter. A copy of the letter was no longer available at the time of the review. The Review Panel was informed that at the time the letter was sent, the GP practice was experiencing issues with electronic notifications, which included discharge letters. The Review Panel was informed that had the discharge letter been received, it would have likely prompted further discussions with Karen by her GP practice. The issue with receipt of discharge letters has since been resolved.

14.5.2 The NHS provides the following advice in relation to alcohol consumption[22]:

'To keep health risks from alcohol to a low level if you drink most weeks:

- men and women are advised not to drink more than 14 units a week on a regular basis,
- spread your drinking over 3 or more days if you regularly drink as much as 14 units a week, and
- if you want to cut down, try to have several drink-free days each week.

14 units is equivalent to 6 pints of average-strength beer or 10 small glasses of lower-strength wine'.

14.5.3 There was no evidence that Karen was provided with advice or signposted to services from either Barnsley Hospital NHS Foundation Trust or her GP practice. It was evident to the Review Panel that there had been an assumption by Barnsley Hospital NHS Foundation Trust that the contents of the letter would be followed up with Karen; however, as the GP practice did not receive the letter, then this action did not take place.

14.5.4 The Review Panel concluded that Barnsley Hospital NHS Foundation Trust should have discussed with Karen, her alcohol consumption and provided her with information on how she could access support. The Review Panel was informed that this is expected practice within Barnsley Hospital NHS Foundation Trust.

14.5.5 The Review Panel obtained information on the prevalence of alcohol consumption across Barnsley and were informed that a study undertaken by the University of Sheffield[23], indicated that there were an estimated 3,839 adults in Barnsley who were alcohol dependent: this equated to 1.97% of the adult population. The refreshed figures (published March 2021) showed an increase of 8%. In comparison to the Yorkshire and Humber regional areas, Barnsley recorded the second highest alcohol prevalence. The Barnsley prevalence rate is also higher than the national average of 1.3%.

14.5.6 Whilst there are no estimated prevalence figures for individuals who are drinking at harmful levels but are not dependant on alcohol, the Health Survey for England 2011 – 2014, showed that a large proportion of the Barnsley adult population, reported that they drank alcohol (85.5%), which was above both the regional and national averages of 83.2% and 84.5% respectively.

[22] https://www.nhs.uk/live-well/alcohol-advice/calculating-alcohol-units/
[23] Study completed in 2017 and updated in March 2021.

	Barnsley	Yorkshire & Humber	England
Drinkers	85.5%	83.2%	84.5%
Abstainers	14.5%	16.8%	15.5%

Health Survey for England 2011 – 2014

14.5.7 In January 2016, the Chief Medical Officer (CMO) issued revised guidance on safe alcohol consumption limits. The guidance advised that in order to keep the risk of alcohol-related harm to a low-level, males, alongside females, should drink no more than 14 units of alcohol per week.

14.5.8 Using the responses from the Health Survey for England 2011 – 2014, this showed that around 1 in 4 adults in Barnsley (25.8%) drank more than 14 units of alcohol a week, which was below the regional rate (26.2%), but slightly above the national rate (25.7%).

14.5.9 The Review Panel had access to Barnsley Metropolitan Borough Council's 'Barnsley Alcohol Plan 2022 – 2025'. The plan takes cognisance of a report published in 2021 by University of Sheffield, which found alcohol fuelled the coronavirus pandemic in different ways. The report documents that the first Covid-19 lockdown was associated with significant changes in alcohol consumption among adults in England, compared with changes throughout the same period a year previously. High-risk drinking prevalence increased comparatively across all groups, but particularly pronounced rises were seen in women and people from less advantaged social grades. Alcohol reduction attempts significantly increased comparatively among high-risk drinkers. There was little evidence of significant changes in the use of support for alcohol reduction.

14.5.10 The Review Panel agreed that the Barnsley Alcohol Plan 2022 – 2025, responded to the identified areas of learning within this review: this negated the need for recommendations to address learning.

14.5.11 South West Yorkshire Partnership NHS Foundation Trust had no knowledge that there were any concerns regarding substance or alcohol use of Karen and Jim. The Review Panel was informed that patients are asked about alcohol and substance use as part of their physiotherapy assessment template, which is asked depending on clinical presentation and clinician's discretion. South West Yorkshire Partnership NHS Foundation Trust stated that there was some information regarding Karen's weekly alcohol consumption on the GP referral to physiotherapy, but that this did not raise any concerns and did not indicate a need for further exploration.

14.5.12 On 13 February 2020, a practice nurse completed a routine health screening with Jim, which elicited that Jim reported that he was drinking 15

units of alcohol per week. Whilst this is slightly above the recommendation weekly units of alcohol, the Review Panel was informed by health colleagues that this did not suggest signs of hazardous drinking.

14.5.13 Information provided to the police by family and friends during the homicide investigation, indicated that Karen and Jim consumed alcohol daily. Daughter 1 stated that their alcohol consumption increased during the Covid-19 pandemic, and she would, at times, find bottles of alcohol hidden in cupboards. Family stated that the arguments between Karen and Jim occurred after they had both consumed alcohol.

14.5.14 Jim told the Chair that he and Karen had a drinking culture, and that they would both drink alcohol every day. Jim stated that whilst he had periods of abstinence, Karen did not. This latter comment from Jim contradicts information provided to the police by family after the murder of Karen, which detailed that Karen had been abstinent from alcohol for around three weeks prior to her murder.

14.5.15 Jim told the Chair that throughout lockdown, they would have deliveries of food and alcohol from two different supermarkets each week. Jim stated that their alcohol consumption increased during the Covid-19 pandemic, and that he often found bottles of alcohol hidden behind curtains.

14.5.16 The extent of Karen and Jim's alcohol consumption was only known to family and friends. Whilst the information provided by family, friends, and Jim appears to indicate that their consumption levels were above the recommended weekly intake, the Review Panel has not been able to confirm this. Daughter 1 told the police, during the homicide investigation, that although her parents consumed alcohol, she would not describe them as alcoholics or alcohol dependent.

14.6 Term 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?

14.6.1 Karen worked with health professionals to respond to her treatment in relation to her long-term illness and physiotherapy. There was no evidence that indicated that Karen was unable to access those services.

14.6.2 The review has identified learning in relation to providing advice and signposting to services in relation to alcohol consumption; therefore, this will not be repeated within this Term of Reference. [See Term 5].

14.7 Term 7

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

14.7.1 The review has identified learning in relation to the use of 'routine enquiry' by health professionals. This has been captured within Term 1, and therefore will not be repeated within this Term of Reference.

14.7.2 As stated within Term 1, none of the agencies who contributed to this review, had knowledge that Karen was a victim of domestic abuse. The Review Panel was informed that with the exception of the use of routine enquiry, single and multi-agency policies and procedures that respond to domestic abuse and safeguarding, are embedded into practice, including knowledge and understanding on the completion of risk assessments and referrals, where necessary to MARAC.

14.7.3 The Review Panel had access to data supplied by IDAS in relation to referrals into MARAC from the police and partner agencies. This data was provided to support that the knowledge on MARAC processes was embedded into practice. The below data demonstrates that MARAC cases in Barnsley per 10,000 population, are above the national average.

	Nationally	Barnsley
2017	36	29
2018	38	38
2019	40	55
2020	44	72
2021	46	77
2022	46	76
2023	47	70

14.7.4 The below data shows the referring agency into MARAC. The data is captured in accordance with Safelives, who categorise under the headings of 'police' and 'partner agency' (which includes everyone else). The data is compared against the national figures.

	National Police %	Barnsley Police %	National partner agency %	Barnsley partner agency %
2017	65%	65%	35%	35%
2018	66%	52%	34%	48%
2019	65%	56%	35%	44%

2020	65%	62%	35%	38%
2021	67%	71%	33%	29%
2022	66%	68%	34%	32%
2023	66%	70%	34%	30%

14.7.5 The Review Panel was also informed that Barnsley Council is in the process of commissioning a comprehensive package of training for professionals from their domestic abuse provider, who has many years' experience of delivering accredited training and has tested this model with other districts.

Titles include:

- Domestic Abuse Signs, Indicators, Assessment and Referral Pathways (DASH and MARAC)
- Coercive Control Workshop
- Honour Based Abuse, Forced Marriage and Female Genital Mutilation
- Supporting Male Victims of Domestic Abuse
- Supporting Older Victims of Domestic Abuse
- Supporting Young People and Domestic Abuse
- Supporting LGBT+ People and Domestic Abuse
- Supporting People with Disabilities and Domestic Abuse
- Substance Abuse and Domestic Abuse
- Supporting People with Mental Health and Domestic Abuse
- MARAC Representatives Training
- Safeguarding Children and Domestic Abuse
- Healthy Relationships Workshop
- Violent Resistance Workshop –
- Trauma and How it Affects Victims Workshop.

To promote this and raise awareness – targeting their professional colleagues – Barnsley Council is increasing the levels of communications across the outlets. Training will be free at source, but partners will be encouraged to commission additional training for longer-term impact and change.

14.8 Term 8

Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Karen and/or Jim, 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.

14.8.1 None of the agencies involved in this review, identified any issues in relation to their capacity or resources during their contact with Karen and Jim.

14.8.2 The timescales of this review covered the commencement of the Covid-19 pandemic. During this time, some of Karen's health appointments were conducted over the telephone and on video, in accordance with guidelines that had been issued. The review has seen that, on occasions, following these contacts, Karen was then offered face-to-face contact with a health professional. This can be evidenced through contact with the physiotherapy department and a GP practice in October and December 2021, respectively.

14.8.3 South Yorkshire Police had no contact with Karen and Jim during the review timescales, until Karen's murder. The Review Panel was informed that throughout the Covid-19 pandemic, South Yorkshire Police did not restrict services that were being offered to victims. South Yorkshire Police worked closely with partner agencies to offer a different kind of service to victims, including victims of domestic abuse, by offering services including the following:

- If a victim rings 999 and they are not in a position to speak due to another party being present, they were advised to press 55. This will notify the operator to the relevant police force, who will assess the background information to make an informed decision on action to be taken.
- If the incident is not urgent, then there is an online portal for victims of domestic abuse to send an email outlining what their issues are and to ask for advice on signposting to other agencies
- If a victim does not wish to speak directly with the police, then Women's Aid held a Monday to Friday Web Chat between 10am – 12pm
- Giving out the number for the National Domestic Abuse Helpline, which operates 24 hours
- Karma Nirvana support lines between 9am – 5pm, Monday to Friday
- The #ThisisnotNormal campaign was developed and rolled out. South Yorkshire Police produced a leaflet to inform and assure victims of the assistance that was still available to them during lockdown, including contact numbers of supporting agencies. This campaign was advertised and posted across all social media platforms, including the South Yorkshire Police internet site.

14.9 Term 9

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

14.9.1 On reviewing all the information provided to the review from family and friends, the Review Panel was clear in their conclusions that Karen had been a victim of domestic abuse and that Jim was the perpetrator of that abuse.

14.9.2 Karen's family described to the police, during information gathered as part of the homicide investigation, of the constant verbal arguments that took place between Karen and Jim, and that they had witnessed these arguments since their early childhood. Karen's family stated that the arguments often occurred after Karen and Jim had consumed alcohol and that there was no pattern to which of the couple instigated the arguments. The Review Panel acknowledged that verbal abuse is a form of domestic abuse.

14.9.3 Karen's family stated that it was only in the last six months prior to her murder that, to their knowledge, Karen was physically assaulted by Jim. None of the incidents of verbal and physical abuse were reported to the police or other agencies by Karen's family.

14.9.4 Daughter 1 told the Chair that she had wanted to telephone the police after her mother had been assaulted on Christmas Day; however, she had not done so for fear that she would end up being blamed, and her parents would both turn against her. Daughter 1 also stated that she was worried that her father might harm himself, and she referenced the incidents from her childhood when she had found him in the preparation of self-harming.

14.9.5 Daughter 1 stated that her parents had a joint bank account. Karen's wages were paid into this account, and Jim transferred money in from his business account. Daughter 1 stated that some of the arguments between Karen and Jim were about money. Daughter 1 stated that after her mother's murder, it was discovered that Karen had taken out a loan at the beginning of 2022 and had balances on credit cards. Daughter 1 also stated that Karen had inherited a sum of money following the death of her mother, but that this had been spent prior to her mother's death. Daughter 1 told the Chair that Karen and Jim's house was well furnished, they had three vehicles, and that Karen had always been generous, financially, towards family and friends. When spoken to by the Chair, Jim stated that Karen was responsible for the family's finances and managed the bank accounts: paying all the bills, etc. This was confirmed by Daughter 1.

14.9.6 The panel considered whether there were indicators of economic and financial abuse in this case. Surviving Economic Abuse[24], the UK charity, describes economic abuse as: 'A legally recognised form of domestic abuse. It often takes place in the context of intimate partner violence. It involves the control of a partner or ex-partner's money, finances and things that money can buy, such as clothing, transport, food and a place to live'. Financial abuse is described as a sub category of economic abuse and includes controlling finances, stealing money, and coercing someone into debt.

14.9.7 The panel acknowledged that the information around the financial matters could have been an indicator of domestic abuse; however, the panel had no direct evidence that this was fact. In speaking with Daughter 1, there was no evidence from the family that the loan and credit cards were due to financial abuse.

14.9.8 Friend 1 described to the police that the injuries she saw on Karen on Christmas Eve were, in her view, consistent with the explanation provided by Karen at the time. Although she queried the mechanism of the fall against the sustained bruising on Karen's eyes, she had no reason at that juncture to indicate that these had been caused by Jim assaulting Karen.

14.9.9 The Review Panel recognised that domestic abuse takes many forms and considered if Karen had been a victim of coercive and controlling behaviour perpetrated by Jim. The Review Panel has seen no evidence that would indicate Karen had been subjected to coercion and control. Karen had contact with family and friends. It was known that Karen went out socialising with friends, often at times going away for long weekends.

14.10 Term 10

Are they any examples of outstanding or innovative practice arising from this review?

14.10.1 The review has not identified any examples of outstanding or innovative practice.

14.11 Term 11

What learning has emerged for your agency, and how will this be addressed?

Barnsley Hospital NHS Foundation Trust

[24] https://survivingeconomicabuse.org/about-us/

14.11.1 Use of routine enquiry.

Responding to indicators of excessive alcohol consumption.

Action taken to address this area of learning:

The Safeguarding Team are reviewing and providing safeguarding oversight of the electronic records of all the Emergency Department attendees who have a domestic abuse flag, to ensure the correct procedures are followed.

NHS South Yorkshire Integrated Care Board – Barnsley (GP Practice)

14.11.2 Ensure all staff receive, and are up to date with, regular adult safeguarding training.

14.12 Term 12

Does this learning appear in other Domestic Homicide Reviews commissioned by Safer Barnsley Partnership Board Partnership?

14.12.1 The Review Panel analysed information known by agencies and family and friends about Karen and Jim. This covered periods during the Covid-19 pandemic. The Review Panel discussed information contained within reports produced by the Vulnerability Knowledge and Practice Programme (VKPP)[25] and considered their latest report: Domestic Homicides and Suspected Victim Suicides 2021 – 2022 Year 2 Report[26].

14.12.2 Within the report, it details: 'Finding 1: There was a rise in both domestic homicides and suspected victim suicides as counted by this Project in Year 2 (April 2021 – March 2022) compared with Year 1 (April 2020 – March 2021). The overall number of domestic homicides relating to an intimate partner, family member or 'other' increased by 16% (n = +23), including a 3% increase in intimate partner homicide (n = +3), a 55% increase in adult family homicide (n = +22), and a small decrease (n = –2) in 'other' deaths, as counted by this Project. Based on the pattern in Year 1 of this Project, we estimate this may increase a bit further due to late submissions'.

14.12.3 Whilst Karen's death was outside of these timeframes, the evidence within the report highlights that domestic homicides by an intimate partner were

[25] ttps://www.vkpp.org.uk/vkpp-work/domestic-homicide-project/
[26] https://www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf

on the increase at the time of her death. The report makes recommendations at a national and local level for agencies responding to victims of domestic abuse. The Review Panel concluded that the information and analysis within the report was relevant for all agencies working within Barnsley.

15. CONCLUSIONS

15.1 Karen was murdered by Jim: her long-term partner and husband.

15.2 Agencies did not know that Karen had been a victim of domestic abuse prior to her murder. There was no information held by agencies that identified Jim as a perpetrator of domestic abuse.

15.3 Karen's family told the Review Panel about their parent's relationship. This consisted of verbal abuse, often on a daily basis, and usually after the consumption of alcohol.

15.4 Towards the end of 2021, Karen had been to her GP practice on two occasions, with injuries she stated had been caused by a fall; there were no indicators during contact with a GP that these injuries were due to domestic abuse.

15.5 At the end of 2021, Karen was physically assaulted by Jim. This was the first time Karen's family were aware of physical abuse in Karen and Jim's relationship.

15.6 There were opportunities during the timescales of this review for Karen to have been asked directly about domestic abuse, particularly during her contact with professionals predominantly working within health organisations. This did not take place. All health organisations involved in this review, identified this as an area of learning and have started to embed changes to their practices.

15.7 As a result of Karen's ill health, she worked from home during the Covid-19 pandemic, with appropriate adaptations and support from her workplace. In the Autumn of 2020, Karen's mother came to stay for palliative care. The review identified that there was a culmination of events during this period that could have placed additional strain on family life. The review recognised that there was an opportunity for Karen to have been provided with information around support that could have been available to help her and her family at this time.

15.8 Karen's death has had a significant impact on her family. The Review Panel expresses its thanks to the family for their support and contribution during the review.

16. LEARNING IDENTIFIED

16.1 The Domestic Homicide Review Panel's Learning (Arising from panel discussions)

16.1.1 The Review Panel identified the following lessons. The panel did not repeat the lessons already identified by agencies in Term 12. Each lesson is preceded by a narrative that seeks to set the context within which the lesson sits. When a lesson leads to an action, a cross reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
Opportunities arose on this case for direct questioning on domestic abuse to have been asked during contact with health professionals.
Lesson
The use of direct questioning on domestic abuse, allows victims of domestic abuse an opportunity to disclose abuse and for professionals to provide advice and support, including referrals to other agencies and early intervention.

Learning 2 [Panel recommendation 2]
Narrative
The impact of undertaking a caring role was not recognised on this case.
Lesson
The identification of the potential impact on families who are undertaking a caring role, particularly during palliative care, and providing those individuals with information as to how they, and their families, can access support during this time.

17. RECOMMENDATIONS

17.1 Panel Recommendations

Number	Recommendation
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

Number	Recommendation
	embed this learning into practice. It is recommended that the report includes statistical data to evidence the impact of the changes that are made.
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.

17.2 Single Agency Recommendations

17.2.1 Single agency recommendation are contained within the Action Plans at Appendix A.

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	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
				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

	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.					
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,	Barnsley Council	31 December 2024

				including what support is available and how to access this.		
				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	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	3.1. 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.
4	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.	4.1 Identify staff training needs in relation to adult safeguarding. 4.2. 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.

End of overview report