For Publication

SAFER STOCKPORT PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Into the death of

Gordon

OVERVIEW REPORT

For Home Office

Chair and Author: David Hunter

Supported by: Paul Cheeseman

Date: November 2018

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1. INTRODUCTION

1.1 In January 2018, Jane, 63 years, walked into a police station in Greater Manchester and told officers she had killed her father Gordon aged 87 years some 10 or 12 years earlier[1] and buried his body in the garden of the house they shared. Immediately after the homicide Jane told her brother Robert, and 18-year-old daughter Sarah, that Gordon had been admitted to hospital, died of blood poisoning and had been cremated. The police found Gordon's body in the place Jane buried him.

1.2 Jane did not report the death and continued to claim Gordon's benefits until her disclosure to the police.

1.3 In July 2018 Jane pleaded guilty to:

Manslaughter:	9 years	imprisonment
Prevention of lawful burial:	2 years	imprisonment concurrent
Benefit Fraud 2006 – 2007:	1 year	imprisonment concurrent
Benefit Fraud 2007 – 2018:	4 years	imprisonment concurrent

1.4 The Court accepted the manslaughter plea on the grounds of diminished responsibility. The sentencing judge is reported as saying, '…he accepted she killed while suffering from post-traumatic stress disorder and severe depression as a result of 40 years of extreme mental, physical and sexual abuse at the hands of your father'.

1.5 This report explores agencies' knowledge and response to the events leading to the homicide of Gordon and describes the circumstances leading to Jane's confession.

1.6 'In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, 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'.[2]

1.7 'The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future'.

[1] This was later established as January 2006

[2] Home Office Guidance Domestic Homicide Reviews December 2016

2. TIMESCALES

2.1 Greater Manchester Police notified Safer Stockport Partnership of the homicide on 19 January 2018. David Hunter was appointed as the independent Chair and author on 28 January 2018.

2.2 On 8 February 2018, Safer Stockport Partnership Board ratified the decision made by local community safety managers that the death of Gordon should be subject to a domestic homicide review.

2.3 The first panel meeting was held on 12 March 2018, at which a time table was set to deliver the review by 31 August 2018. At the second panel meeting on 16 May 2018 it was apparent that completion by 31 August 2018 was impractical for the following reasons.

- The trial was not schedule to begin until 9 July 2018 and was set for two weeks.
- There was very little information available from agencies and it was envisaged most material will come from the trial.
- The victim's family was being supported by Victim Support's National Homicide Team. The worker has advised they are too fragile to engage at this time.
- There will be insufficient time from 23 July 2018 [anticipate trial end date] and 31 August 2018 for the panel to complete the work which, in the event of a conviction, will involve negotiations to see the offender.

2.4 The Chair of Safer Stockport Partnership was briefed on the need to reschedule the completion date and agreed to the proposed end date of 31 October 2018. This was later extended to 30 November 2018 to allow additional time to involve the family and Jane.

2.5 The domestic homicide review was presented to Safer Stockport Partnership on 20 November 2018 and sent to the Home Office a week later.

3. CONFIDENTIALITY

3.1 Until the report is published it is marked: Official Sensitive Government Security Classifications April 2014.

3.2 The Panel Chair notified Gordon's family of the review through the good offices of Victim Support National Homicide Team. The pseudonyms used in this report to protect identities were chosen by the review Chair. Sarah, Robert and Jane were written to saying what the chosen pseudonyms were. Robert and Sarah responded saying they were content with the chosen pseudonyms. Professionals are referred to by an appropriate designation.

3.3 This table shows the age and ethnicity of the victim and offender at the time of the homicide in 2006.

Name	Who	Age	Ethnicity
Gordon	Victim	87	White British
Jane	Offender	51	White British
Sarah	Jane's daughter	17	White British

3.4 Address 1 was Gordon's rented home where he lived with Jane and Sarah.

4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference at its first meeting on 12 March 2018. They were not shared with Gordon's family at that time because Victim Support's National Homicide Team judged the family was not ready to be involved with the review. As will be seen later family involvement was not possible.

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]

Timeframe under Review

The DHR covers the period: from 9 November 2005 to 7 January 2018.

Subjects of the DHR

Victim	Gordon
Offender	Jane
Daughter of Jane	Sarah

Specific Terms

1. What was the family history of domestic abuse and or child protection matters leading up to the homicide of Gordon?

2. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Gordon, Jane or Sarah as victims of domestic abuse and what was the response?

3. What services did your agency offer the victims?

4. What knowledge did your agency have that indicated Jane might be, or had the potential to be, a perpetrator of domestic abuse and what was the response?

5. What enquiries did you agency make to ascertain whether Gordon needed services, who were they made to and what was your response to the replies?

6. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Gordon, Jane and Sarah?

7. What learning has emerged for your agency?

8. Are there any examples of outstanding or innovative practice arising from this case?

9. Does the learning in this review appear in other domestic homicide reviews or safeguarding adult reviews commissioned by the Safer Stockport Partnership or Stockport Safeguarding Adults Board?

5. METHODOLOGY

5.1 The first meeting of the domestic homicide review panel decided the period under analysis should begin on 9 November 2005 which is a few months before Gordon was believed to have died and end in early January 2018 when Jane told the police about the death.

5.2 On 7 January 2018, Safer Stockport Partnership asked ten agencies what information relevant to the terms of reference they held on the subjects of the review. Six replied that they held no relevant information.

5.3 Four agencies held some information; three provided it by way of individual management reviews [IMR][3] and one submitted a short report.
The Senior Investigating Officer from Greater Manchester Police helpfully provided information gained from the murder investigation.

5.4 Panel members used the above material as the basis for their discussions. When queries arose, these were researched by the appropriate agency and the answers contributed to the debate.

5.5 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed. Prior to publication the report was shared with Gordon's family who have affirmed its accuracy.

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

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

6.1 The Panel Chair drafted letters to be sent to Gordon's son, Robert and granddaughter and was advised by the homicide support worker from Victim Support and the police family liaison officer that it would be inappropriate to give the letters to the family at this time because they were too fragile.

6.2 The homicide support worker from Victim Support alerted the panel chair when the time was right to engage with the family and delivered the letters to them. The letters included the Home Office Domestic Homicide Review leaflet for Families, and the Advocacy After Fatal Domestic Abuse[4] leaflet and terms of reference.

6.3 Robert felt unable to contribute to the review while Sarah was considering what to do. Neither Gordon nor Jane were employed and they appeared to have lived a fairly isolated and insular life without any friends. Their neighbours had very limited knowledge of the family and what they knew was irrelevant to the terms of reference.

6.4 In late October 2018 Victim Support forwarded the following to the review in answer to a question whether Sarah had seen version 2 of the report. 'Sarah is aware of the report but despite a number of attempts by myself and one of my volunteers to contact her she is not responding'.

6.5 Jane's prison Offender Supervisor delivered a letter from the Chair of the review, informing her of the review and asking if she would like to contribute. Jane said she was nervous about doing so and would think about it.

6.6 In late October 2018 the Offender Supervisor passed the following message to the Chair. 'I met with Jane this morning, I explained the review process as I've been involved in other reviews at [the name of the prison has been redacted] but Jane declined. She commented that she was not involved with any services in the community and is also hoping to engage in psychological intervention soon. I get the impression she may have been concerned about the emotional impact this process may have had on her. I did reinforce the purpose of the review as a learning exercise for professional bodies with little emphasis on the index offence however she made it clear she does not want to be involved'.

6.7 On 31 October 2018 the Chair wrote to Robert and Sarah explaining that the review had been completed and offering them an opportunity to see the report before it was presented to the Community Safety Partnership and sent to the Home Office. Included in the letter were the proposed pseudonyms with a question soliciting approval or objections. Robert replied

[4] www.aafda.org.uk A centre of excellence for reviews into domestic homicides and for specialist peer support

in writing saying he was content with the pseudonym and did not want to see the report before it was sent to the Home Office. He wanted to be informed of its publication. Sarah did not reply. Both were then written to prior to publication, inviting them to see the report. Sarah and Robert have both subsequently reviewed the report and provided feedback on pseudonyms and matters of accuracy.

6.8 The Chair also wrote to Jane via her Offender Supervisor in prison inviting Jane to see the report which had embedded in it the critical questions the Chair would have asked Jane had she agreed to be seen. The Chair asked the Offender Supervisor to use her discretion on whether Jane was well enough to receive the letter and report. The Offender Supervisor consulted Jane's mental health professional who felt it was not appropriate for Jane to see the documents at this time. That position will be kept under review. Jane and her Offender Supervisor will be notified of the publication date in advance.

7. CONTRIBUTORS TO THE REVIEW.

7.1 The following agencies provided information to the review.

Agency	IMR	Short Report
Department for Work and Pensions		✓
Greater Manchester Police		✓
NHS Stockport Clinical Commissioning Group	✓	
Stockport Homes Group	✓	

7.2 Agencies held very little information on Gordon and his family. The background to the homicide emerged during the police investigation which was significant to the panel's understanding of what happened to Gordon.

7.3 Unfortunately the review had to be completed without the benefit of the family or offender's involvement. This means that the review had to rely on third party reporting, or statements they made to the police, to gain an impression of the family's thinking.

8. THE REVIEW PANEL MEMBERS

8.1 The panel members were:

Name	Job Title	Organisation
Kath Carey	Strategy & Performance Manager	Stockport Council Safeguarding & Learning
Paul Cheeseman	Support to Chair	Independent
Mark Fitton	Director of Operations	Adult Social Care Stockport Council
Naz Ghodrati	Chief Executive Officer	Stockport Without Abuse [SWA]
Julie Parker	Head of Safeguarding	NHS Stockport CCG
Jo Richardson	Neighbourhood Housing Manager	Stockport Homes
Jenny Stanton	Partnership Manager	Department for Work and Pensions
Wendy Stewart	Stockport NHS Foundation Trust	Named Nurse Adult Safeguarding
Alison Troisi	Greater Manchester Police	Detective Sergeant
Duncan Thorpe	Greater Manchester Police	Senior Investigating Officer
David Hunter	Chair and author	Independent

8.2 The Chair of Safer Stockport Partnership was satisfied that the panel chair was independent. The panel chair believed there was suitable independence and knowledge on the panel to objectively scrutinise the events and prepare a balanced report.

8.3 The Panel met four times and the circumstances of Gordon's homicide were considered in detail to ensure all possible learning could be obtained from his death.

9. 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 set out the requirements for review chairs and authors. In this case the chair and author was the same person, a position allowed by the guidance.

9.2 The chair completed forty-one years in public service [The Armed Services and a British police service] retiring from full time work in 2007. Since then he has undertaken the following types of reviews.
Child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews, domestic homicide reviews and ad hoc investigations.

9.3 He chaired one domestic homicide review in Stockport in 2016 and several Safeguarding Adult Reviews in the last three years. He has never worked for any agency providing information to the current review.

9.4 The chair was supported by Paul Cheeseman, an independent practitioner with a similar professional background and experience.

10. PARALLEL REVIEWS

10.1 HM Coroner for Stockport opened and adjourned an inquest and as of 13 November 2018 had not decided whether to resume the inquest. Greater Manchester Police undertook a criminal investigation.

10.2 The review panel did not identify any other reviews in connection with Gordon's death.

11. EQUALITY AND DIVERSITY

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

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- 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[5]

11.3 Neither Gordon, Jane nor Sarah had any known disabilities.

11.4 The panel found evidence that the family accessed local services and concluded that neither of them faced any barriers relevant to equality and diversity.

11.5 There is no suggestion that any of them lacked capacity or had any impairment that prevented them from carrying out day to day activities.

11.6 When Jane was questioned by the police following her arrest on suspicion of murdering Gordon it was done in the presence of a solicitor and 'Appropriate Adult' suggesting that at that time she was mentally vulnerable.

Note:

GUIDANCE FOR APPROPRIATE ADULTS The Police and Criminal Evidence Act 1984 (PACE) Codes of Practice provide for an appropriate adult to be called to the police station whenever a juvenile or mentally vulnerable person has been detained in police custody. Appropriate adults have an important role to play in the custody environment by ensuring that the detained person whom they are assisting understands what is happening to them and why.

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

12. DISSEMINATION

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

- The victim's family
- The perpetrator's Offender Manager and Offender supervisor from National Probation Service
- Safer Stockport Partnership Board members
- Home Office
- The Mayor of Greater Manchester. This elected office incorporates the role of the former Police and Crime Commissioner
- HM Coroner for Stockport on request

13. BACKGROUND, CHRONOLOGY and OVERVIEW

13.1 The background, chronology and overview sections of the Home Office domestic homicide review overview report template have been combined into one section in this report for two reasons: to avoid duplication and to reflect the very limited contact agencies had with Gordon, Jane and Sarah.

13.2 The background to the homicide of Gordon, and its discovery, is rare if not unique.

13.3 Firstly, it was committed in January 2006 some five years before domestic homicide reviews were introduced. Secondly, Gordon's homicide was passed off as a natural death by Jane and no one in the family raised any real queries. Thirdly, Gordon's death remained hidden for twelve years until January 2018, the year he would have been a centenarian. Fourthly, Jane was able to claim Gordon's benefits for twelve years before being effectively challenged.

13.4 The narrative is told chronologically to avoid repetition. It is built on the lives of the family and punctuated by subheadings to aid understanding. The source of the information is from documents provided by agencies and material gathered by the police during the homicide investigation. Sadly, the review had to be completed without direct family input.

Gordon

13.5 Gordon was born in the Halton area during the last few months of World War 1 [1918]. Little is known about his childhood, schooling or early employment. He took up the tenancy of Address 1 in 1963 and held it until the discovery of his death in 2018.

His Military Service

13.6 In July 1939, Gordon, 20 years, was called up for military service and enlisted in the Light Anti-Aircraft Regiment, Royal Artillery as an aircraft fitter and later qualified as a vehicle mechanic. During World War 2, he saw active service in the Middle East, North Africa and Europe. He was awarded: the Africa Star; 8th Army Clasp; 1939-1945 Star; Italy Star; France and Germany Star; War Medal and Defence Medal.

13.7 Gordon was discharged in May 1946 with an exemplary conduct record. His last Commanding Officer wrote, 'A first class and invaluable mechanic who always worked willingly and well as his trade courses and tests passed show. He is a most honest cheerful and reliable man'.

His Marriage

13.8 Gordon married about a year after demobilisation and lived with his wife in a Stockport suburb. The couple had three children: First born was Henry followed by Robert and Jane.

13.9 Robert described his father's health as generally good and his parents' marriage as unremarkable until about 1967 at which time they began arguing and shouting. He recalls in a written statement '... tea cups were

thrown against the kitchen wall, things like that, ordinary couple stuff'. Robert moved out of the family home in 1967 and his parents separated in about 1968. He recalls that his father was very bitter after the divorce. Robert did not know what led to the breakdown of his parents' marriage. Robert's mother died of natural causes in her forties.

His Work

13.10 Gordon worked at ICL [International Computers Limited] Manchester building computers. He retired in 1982/83. A former work colleague told the police about an incident at ICL that happened around 1978 when Gordon showed him and other colleagues a posed picture of a naked female sitting on a chair. Gordon said it was his daughter.

His Retirement

13.11 Little is known about how Gordon spent his time after retiring. He seems to have had an interest in photography and gardening. In 2004 his General Practitioner [GP] noted, following a health check, 'normal blood pressure and body mass index and seemingly in good health'. Gordon was 86 years of age.

His Disposition

13.12 Several family members described Gordon as very controlling towards his children who left home on becoming independent. Robert's account of tea cups being thrown suggests the children grew up in a home where domestic abuse was present.

13.13 Henry recalls a family argument when he was living at home following which he and his siblings moved out of the house leaving Gordon living alone until Jane moved back in following their mother's death. He does not remember what the argument was about.

Jane

13.14 Jane was born in 1954 and lived in the family home with her parents and siblings. She was educated in Stockport. In 1969 Jane was taken to court for non-attendance at school. A letter on her medical record noted, 'Some family trouble involved. Very depressed… highly verbal & threatening suicide'. In the same year it was noted she took an overdose of painkillers. There is no further explanation or facts. On leaving school she had a few mill jobs in her late teens and during her 20's she worked in a factory that made hats, and later, at a textile factory, sorting pieces of tracksuits into bundles for the machinists.

13.15 At some point after her parent's separation Jane moved in with her mother before returning to live with her father at Address 1 in about 1973. Her mother died when Jane was in her mid-twenties.

13.16 In 1987 Jane married Brian at Stockport Registry Office having known him for about a year. Jane moved out of the family home and lived with Brian in a different part of Stockport. Sarah, their only child, was born a year later.

13.17 Jane and Brian separated in 1991 or 1992 and Jane and Sarah moved into Gordon's house. Brian saw Sarah less and less and eventually lost touch with her and Jane. Sarah described her bond with Jane as a normal mum and daughter relationship. Sarah said Jane's mental state was average and her mother always suffered with depression and self-harmed by cutting her wrists.

13.18 In 1998 Jane was treated by her doctor for 'long term history of depression'. The GP IMR noted, 'The precipitating and perpetuating factors underlying this depression were not documented. She subsequently was involved in a road traffic accident, and went on to suffer with post-traumatic stress disorder. She seemingly accessed psychological therapy in this regard, but no mention is made of her underlying depression prior to the accident'.

13.19 After Gordon's death Jane's mental health did not differ; Sarah felt it deteriorated in about 2014. Jane did not have any friends and lived quite an isolated life. It is thought she was not in regular employment and as will be seen later lived on the income she unlawfully claimed following Gordon's death. There is some evidence that she had casual work as a cleaner in retail settings.

Gordon and Jane**'s Relationship**

13.20 The following passages are taken from accounts provided by family members and illustrate the nature of the relationship between Gordon and his daughter. Gordon's behaviour would now be recognised as controlling and coercive.

- Gordon was controlling and verbally aggressive and physically abusive towards Jane and her brothers.
- Gordon was controlling and verbally aggressive towards Sarah and made one inappropriate suggestion to her that had sexual undertones. Sarah was 16 years at the time.
- Jane and Gordon's relationship was quite strained.
- There was lots of aggression and arguments, however there are always rows in families.
- The aggression was spontaneous towards Jane and Sarah.
- Gordon's controlling nature was a causative factor in Brian losing touch with Jane and Sarah.
- One family member said they thought the relationship between Gordon and Jane worked well.
- He was a bully and liked to show people up and make them feel uncomfortable.
- The trial judge accepted that Jane killed Gordon while suffering from post-traumatic stress disorder and severe depression as a result of '40

years of extreme mental, physical and sexual abuse at the hands of your father'.

- Jane told police that on the day of the homicide, '…she was doing gardening, which she had been instructed to do by her father.

Gordon's Death as Initially Explained to the Family by Jane

13.21 The family had very infrequent contact with each other and years would pass without communication. It appears the isolation was mutual and stemmed from their experiences while living at home.

13.22 Jane killed Gordon in January 2006. Sarah learned of his death later that day when she returned from college. Jane said Gordon had been taken to hospital and died of blood poisoning and had been cremated. Two days later Jane told Robert a similar story. At the time neither of them thought there was anything suspicious about Gordon's death. Some years later Sarah wondered why she could not find a record of his death and spoke to Jane about the circumstances. Jane became upset and Sarah did not pursue the matter further. Robert thought his father had died from a heart attack accepting, '… that your parents do not live forever'.

13.23 Sarah and Robert were shocked when the truth emerged about how Gordon died.

Agencies Contact with Jane post Gordon's Homicide

13.24 After Gordon's death Jane continued to claim his allowances and live at Address 1. Stockport Homes, the Department for Work and Pensions and Gordon's GP had no inkling that he was dead.

13.25 It is now known that Jane used many excuses to account for Gordon's non-engagement with his doctor and other services. For example, in March 2006 Gordon failed to keep an appointment at Manchester Dental Hospital who noted, 'Patient did not attend appointment. Phoned home address but wife said that he had informed MDH several times that he no longer wants any appointments.'

13.26 In 2009, Gordon was invited by his GP practice to attend for his annual influenza vaccination, hereinafter referred to as a flu jab. The practice received a letter purportedly signed by Gordon saying his son was now back in his life and would be taking a more active role in maintaining his health. The letter also stated that he was reading self-help books and taking vitamins and was feeling very well. It advised that he no longer wanted to be invited for flu vaccinations and that he was planning to travel soon, along with his son and grandchildren to visit his sister. The letter ended, '…boredom is the only thing to kill me off and I not letting that happen just yet'. This letter was fabricated by Jane. Thereafter, Gordon was written to another eight times inviting him to have an annual flu jab. In 2009 it was noted by Jane's GP that she was a carer.

13.27 In 2009, the Department for Works and Pensions sent Gordon a letter asking if there were any changes to report to his income and noted, 'no reply received,' Payments continued at the same rate into the same accounts. The details of the benefits received by Gordon and dishonestly appropriated by Jane appear later in the report.

13.28 In 2009, Stockport Homes began current tenancy visits to check that: residents had no issues in their home, the correct people were living there and to determine whether there were any tenancy issues.

13.29 In 2011, a Housing Officer from Stockport Homes undertook a current tenancy visit to Address 1 and took identity proof that Gordon was living there. Stockport Homes are unable to confirm who attended the visit in June 2011 and what proof was seen although records show that some identification was seen at the time of the visit. Jane and Sarah were known as being authorised occupants at the address, and the Housing Officer did not recall any reason for concern.

13.30 In 2011, Jane was referred by her GP to a specialist because of concerns about her short-term memory. She did not attend the appointment and there the matter lay.

13.31 In 2013, Jane's GP noted she was a carer for her father who was registered at a different surgery.

13.32 Also in 2013, Stockport Homes began winter welfare visits to elderly and vulnerable tenants to check they had the support and assistance needed during poor weather. Address 1 was visited on 10 January 2014 when access was not gained. The visit was rescheduled.

13.33 In February 2014, a combined winter welfare and current tenancy visit was completed by a Neighbourhood Housing Officer [NHO1]. The electronic records show that the visit was conducted to the property and the answers given did not alert the officer that there was any vulnerability or any cause for concern. Bank statements were seen as identification but it has not been possible to confirm which person[s] was seen. During this visit there were no concerns about the property's condition or anything else that would lead the officer to take any follow up action. The officer was unable to recall the exact content of discussion, except to say that, the explanation at the time must have been plausible as to why the tenant was unavailable at the visit. Jane and Sarah were noted as authorised occupants.

13.34 In November 2017, Jane saw her GP who referred her to the mental health team as she was reporting visual and possible auditory hallucinations. It was documented in the referral that she posed 'no risk'. The Early Intervention Team contacted her, at which point she reported she was feeling better and declined their input.

13.35 On 27 November 2017, NHO1 from Stockport Homes conducted a current tenancy visit and persistent in seeing Gordon along with photographic identification. Jane made unconvincing excuses for Gordon's absence and another appointment was made for 8 January 2018. The last time any

agency had contact with the family before the homicide was 27 November 2017. Stockport Homes carried out routine and reported maintenance at Address 1. There is no cause for concern recorded against any of the jobs undertaken. Stockport Homes would not insist that the tenant was in attendance for work to be completed.

13.36 On 6 January 2018, Robert received a gift card saying, 'If Sarah leaves, can you give her a room to lie down in...you've got each other now.' It was a cryptic message and Robert interpreted it to mean that Jane and Sarah had had a significant argument. Robert assumed the unsigned card came from Jane as it spoke about his niece.

13.37 In a victim impact statement, Sarah said her heart was broken at what had happened and how she had been deceived but would stand by her mother saying, 'I hope when this is done, we can repair our relationship to something approaching normal'.

14. ANALYSIS USING THE TERMS OF REFERENCE

14.1 Introduction

14.1.1 The panel decided the focus of the review should be threefold. Firstly, why the long-term domestic abuse within the family was not reported or discovered by any agency; secondly, what barriers existed that prevented Jane from disclosing that she had been a victim of domestic and sexual abuse perpetrated by her father and thirdly, why Gordon's homicide went undiscovered for 12 years.

14.1.2 The panel was also conscious that whatever the situation, the victim of the homicide was Gordon. The court recognised Jane's extenuating circumstances by accepting her plea of guilty to manslaughter on the grounds of diminished responsibility. The court also accepted she had been the victim of long term domestic and sexual abuse by Gordon. However, as reflected by the conviction and sentence, taking Gordon's life was a criminal act for which Jane was held to account. While the panel do not support her actions and her concealment of the murder, it is important to consider the context of her actions; she had been subjected to an extensive history of domestic abuse and sexual abuse perpetrated by her father.

14.1.3 While it is undeniable that Jane was a perpetrator of homicide, the panel have also considered her life as a long-term victim of domestic and sexual abuse. While this should not excuse her behaviour, it puts it in context.

14.2 Term 1

What was the family history of domestic abuse and or child protection matters leading up to the homicide of Gordon?

14.2.1 No agency held any information or harboured any suspicions that there was domestic or sexual abuse within the family. This is true for the period under review [January 2006 to January 2018] and for period preceding it.

14.2.2 The family accounts that emerged after Gordon's death revealed that there was significant domestic and sexual abuse within the household. However, neither the domestic nor sexual abuse of Jane by Gordon was known about outside of the family prior to the homicide.

Non-Sexual Domestic Abuse

14.2.3 There is no doubt from the descriptions given by family members that Gordon's conduct was abusive with significant elements of controlling and coercive behaviour as set out in paragraph 13.20. Gordon was brought up in an era [pre-World War 2] when domestic abuse was not spoken about openly, albeit there is nothing to suggest he came from an abusive family.

14.2.4 Jane was the last of Gordon's three children to be born and she became an adult in 1972 by which time she and her elder siblings had endured many years of physical abuse and verbal aggression from Gordon. Jane's mother, now deceased, left the family home in about 1968 when Jane was 14 years old. The reasons for the marriage breakdown are not known. The panel felt that the approach to domestic abuse in 1972 was limited and therefore it was not surprised when agencies reported no knowledge it. Robert's account of cups being thrown between his parents is portrayed by him, as 'normal', and is probably indicative of how domestic abuse was perceived in the 1960s and early 1970s.

14.2.5 If Gordon perpetrated domestic abuse in 2018 the opportunities for it to come to the attention of agencies would be so much greater. For example, through: victim reporting, midwifery, health visiting, education, general practitioners and the police.

Sexual Abuse of Jane by Gordon

14.2.6 Gordon's sexual abuse of Jane's was not known about until after she was charged with his murder. The barriers to not revealing it were so great that even when charged with murder she remained silent. It took the skills and experience of a psychiatrist during a fourth meeting to draw the truth out.

14.2.7 Jane was described at Manchester Crown Court as a 'quiet and timid middle-aged lady' who had suffered 40 years of physical and verbal torment from her 'formidable' ex-military father and then 'snapped'. The prosecution accepted that she was suffering post-traumatic stress disorder and a severe depressive illness which 'substantially impaired' her responsibility.

14.2.8 That post-traumatic stress disorder emanated from her sexual and non-sexual abuse by her father. Had a professional known about Jane's victimisation events may have been different.

14.2.9 The panel's collective experience and knowledge of victims of sexual abuse identified that a fear of not being believed as a significant barrier to disclosure. Other barriers to disclosure faced by female victims of familial sexual include.

- limited support [6]
- perceived negative consequences and feelings of self-blame
- shame and guilt when choosing to disclose

[6] Barriers and facilitators to disclosing sexual abuse in childhood and adolescence: A systematic review. Lemaigre C, Taylor EP, Gittoes C. www.ncbi.nlm.nih.gov/pubmed/28551460

14.2.10 The same publication noted. 'The review identifies the need for developmentally appropriate school-based intervention programmes that facilitate children's disclosure by reducing feelings of responsibility, self-blame, guilt and shame. In addition, prevention programmes should encourage family members, friends and frontline professionals to identify clues of sexual abuse, to explicitly ask children about the possibility of sexual abuse and also to respond supportively should disclosures occur. Facilitating disclosure in this way is key to safeguarding victims and promoting better outcomes for child and adolescent survivors of sexual abuse'.

14.2.11 Another study noted that barriers to disclosure outweigh facilitators.[7]

14.2.12 A United Kingdom study listed the following barriers.[8]

- Fear of what will happen
- Others' reactions: fear of disbelief
- Emotions and impact of the abuse
- An opportunity to tell
- Concern for self and others
- Feelings towards the abuser.

14.2.13 Had Jane contributed to the review the actual barriers she faced would probably have materialised.

14.2.14 The panel felt that the local and nationally multi-agency work done in the last ten years to raise awareness around sexual abuse should help victims of historical and current abuse sexual abuse to report their experiences in the confidence that they will be taken seriously, supported, and the crimes against them investigated, if that is what they want.

Child Protection

14.2.15 The links between domestic abuse and child protection were less clear in 1972 and no agency then had any indication that the children were victims of direct abuse or had witnessed abuse between their parents. The 2018 child safeguarding processes are well defined and the relationship between domestic abuse and child protection widely understood.

14.2.16 Sarah was 17 years old at the time of Gordon's death and therefore a child as defined by the Children Act 1989. There was nothing known to Children's Services either before or after Gordon's death about Jane's abuse or Sarah's exposure to domestic abuse.

[7] www.journals.sagepub.com/doi/full/10.1177/1524838017697312

[8] Children's Disclosure of Sexual Abuse: A Systematic Review of Barriers and Facilitators. S. Morrison, C. Bruce & S. Willson 2016

14.3 Term 2

What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Gordon, Jane or Sarah as victims of domestic abuse and what was the response?

14.3.1 Only one agency reported a potential indicator of domestic abuse and that was fairly tangential and about 37 years prior to the homicide. In 1969 Jane's GP noted, 'some family trouble involved' when he saw her following truancy. The nature of that trouble is not specified. Whether or not it related to domestic or sexual abuse cannot be known. Current policies and practice require a greater explanation of such consultations to be recorded and if necessary appropriate referrals made.

14.3.2 Jane tried to self-harm in 1969 and was noted by her GP to be very depressed. Depression was a recurring condition for Jane and in 1998 her medical record showed, 'long term history of depression'. The links between depression and domestic violence were not well developed then and it would not be fair to offer an adverse comment.

14.3.3 An opportunity existed in 1998 for Jane's GP to ask her about the underlying reason for her long-term depression. It is now known that in 1998 Gordon had been sexually abusing Jane for about 39 years.

14.3.4 In February 2014 National Institute for Health and Care Excellence [NICE] delivered what it described as a wakeup call to the NHS and social care services on domestic violence. Part of the document contained the following passage. [9]

'Professor Gene Feder, Professor of Primary Health Care at the University of Bristol and chair of the group which developed the NICE guidance, said, "... Women experiencing domestic violence and abuse have a three times greater risk of depression, four times greater risk of anxiety and seven times greater risk of post-traumatic stress disorder. This guidance promotes a more active role for health and social care services which have always dealt with the consequences of domestic violence, even when professionals did not realise the abuse was occurring. We need patients to feel safe to tell us what really happened to them'.

14.3.5 In February 2016 National Institute for Health and Care Excellence [NICE] issued Quality Standard 116 which related to domestic violence and abuse. Quality Statement 1 of the Standard says: 'Asking about domestic violence and abuse and has the following requirement'.

Statement 1. People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion'.

[9] www.nice.org.uk/guidance/qs116

14.3.6 Knowledge and practice in 1969 and 1999 would not have seen a GP link depression in a patient with being a victim of domestic abuse or sexual abuse. Contemporary good practice requires doctors seeing patients with depression to ask them about domestic abuse.

14.4 Term 3

What services did your agency offer the victims?

14.4.1 Gordon and Jane received universal services from health, housing and benefit agencies and their demand on services was minimal. As a father and daughter living in the same house, they drew practically no attention to themselves. Their neighbours knew little about them and never had cause to refer them to an agency for help or support. They were by all accounts self-sufficient and private people.

14.4.2 Jane was a child and adult victim of extreme and enduring sexual abuse by Gordon. She was born in the mid 1950's when professionals' understanding and approach to child sexual abuse was not as refined as it now is. The public's awareness of child abuse was also unsophisticated.

14.4.3 Public awareness grew as the following enquires reported.

Year	Case
1973	Maria Colwell
1984	Jasmine Beckford
1994	Rikki Neave
2000	Victoria Climbié
2007	Peter Connelly

14.4.4 Alongside awareness, services for victims of child and adult sexual abuse also grew. For example, Child medicals were undertaken in clinical settings by specialists as opposed to being done in police station surgeries by police surgeons. Sexual Abuse Referral Centres were developed to provide a safe and supportive environment for victims, including pathways to other services such as counselling and survivors' groups.

14.4.5 Stockport uses these services to support victims and an internet search using the question, 'What services are available to victims of child and adult sexual abuse in Stockport' returns contacts for many agencies.

14.4.6 However, the barriers that victims face in reporting sexual abuse as outline in this report still exist.

14.5 Term 4

What knowledge did your agency have that indicated Jane might be, or had the potential to be, a perpetrator of domestic abuse and what was the response?

14.5.1 Prior to the death of Gordon in 2006 no agency had any indicators, suspicions or opportunities to identify Jane as a perpetrator of domestic abuse.

14.5.2 After Gordon's death in January 2006, some opportunities existed to identify that he was not alive and by deduction and investigation that Jane might have harmed him. However, these were very limited and the panel did not believe they were significant.

Manchester Dental Hospital

14.5.3 The first of these came in March 2006, when Gordon failed to attend an appointment at Manchester Dental Hospital [MDH]. The MDH medical record shows, 'Patient did not attend appointment. Phoned home address but wife said that he had informed MDH several times that he no longer wants any appointments.' At that time Gordon would have been 87 years of age. He was not married and therefore MDH could not have spoken to his wife. It is almost certain they spoke with Jane whose reply was designed to stop any more contact and the accompanying danger that such contact might uncover Gordon's death. It is not known what the dental appointment was for and whether MDH wrote to Gordon's GP or dentist to inform them of the non-attendance. The panel heard from its GP member that dentists do not routinely inform GPs when their patients 'did not attend' and after a debate the panel felt the circumstances of this case did not merit making a recommendation.

GP Medical Centre

14.5.4 The next opportunity came in October 2006, when Gordon's medical practice wrote to him soliciting his attendance for an annual flu jab. In response to the letter, 'Gordon' wrote back stating that his son was now back in his life and would be taking a more active role in maintaining his health. The letter also said that he was reading self-help books, was taking vitamins and was feeling very well. It was advised that he no longer wanted to be invited for flu vaccinations and that he was planning to travel soon, along with his son and grandchildren to visit his sister. The letter ended stating 'Boredom is the only thing to kill me off & I not letting [sic] that happen just yet'.

14.5.5 The Clinical Commissioning Group's individual management review author discussed the case with the current practice manager. All the GPs who dealt with Gordon have retired. There are some staff remaining who remember him. They are '… unable to clearly say whether this letter was out of character for him or not…' The author gained the impression from reading Gordon's interaction with the orthopaedic team and the follow up letter detailing his description of his 'war wounds,' that he was quite a character and that the letter sent to the practice might have been in keeping with his personality at that time, though is not possible to be sure. Subsequent to the receipt of this letter, Gordon was not seen in the practice or other medical setting again. The GP practice sent letters inviting him to attend for a flue jab in: 2007, 2008, 2009, 2011, 2013, 2014, 2015

and 2017. On each occasion the letter was returned to the practice, signed with Gordon's name indicating that he did not want his flu jab.

14.5.6 The panel discussed whether it was realistic for the medical practice to have spotted the initial and subsequent 'fake correspondence' and to have thought whether he was still alive. It felt it was unreasonable to have expected the medical practice to have launched an inquiry into Gordon's well-being based on the initial fraudulent communication. The older Gordon got and the more letters purporting to come from him rejecting his annual flu jab, the greater was the case for the medical practice to have instigated additional enquiries.

14.5.7 Had the Manchester Dental Hospital notified Gordon's GP of the 'did not attend' appointment of March 2006, the medical practice would have had been able to consider that alongside the initial fake letter sent to the medical centre some seven months later. However, while that would have provided evidence of non-attendance at the MDH, it is still unlikely that the medical practice would have pursued Gordon even with two pieces of information.

14.5.8 The only mention of risk came in November 2017 when Jane's GP judged she posed, 'no risk' when referring her to the mental health Early Intervention Team. The panel queried what 'no risk' meant with the GP IMR author and elicited the following response. 'It is impossible to say as the note was so brief from what I recall – I presume they felt she was 'no risk' to either herself or others, as if they felt she was a risk to anyone, the detail would have been there'.

Stockport Homes

14.5.9 Stockport Homes was Gordon's landlord and Jane and Sarah were authorised residents. The rent was always paid on time and there was not any record of anti-social behaviour or domestic abuse. In brief the tenancy was unremarkable.

14.5.10 In 2009, Stockport Homes began triennial current tenancy visits, to check whether residents had issues in their homes and that the correct people were living there. In 2011, a Housing Officer visited Gordon's home. By this time Stockport Homes required Neighbourhood Housing Officers to check the identity of the tenant to ensure that the person who held the tenancy was the person living in the property. It is not clear from the housing record whether the Housing Officer took proof of identity or accepted a reason why Gordon was not available.

14.5.11 In 2013, Stockport Homes began winter welfare visits to elderly and vulnerable tenants to check they had the support and assistance needed during poor weather. Following the 2014 winter welfare visit, Stockport Homes noted on the file, 'No cause for concern'. It is not possible to

ascertain from the record who was seen and what reason was given for Gordon's absence.

14.5.12 The notes of the 2014 current tenancy visit, record that proof of identity was taken. Bank statements or utility bills were accepted as identification. Photographic identification was not necessarily insisted upon. In this case the identification provided was bank statements.

14.5.13 On 8 November 2017, NHO1 went to Gordon's house by appointment to conduct a winter welfare visit. NHO1 was met in the front garden by a woman who introduced herself as Jane, Gordon's daughter. NHO1 thought Jane had intercepted her and was ready and waiting for the visit. Jane explained to NHO1 that Gordon was visiting a Buddhist convention in Manchester. Jane painted a picture that Gordon was well and out and about. NHO1 reported being impressed that he was still so active because of his age [99 years]. In Gordon's absence NHO1 gave Jane the winter welfare pack and explained that it was necessary to re-visit to see Gordon in person. Jane appeared annoyed that NHO1 insisted on returning to the address.

14.5.14 NHO1 rearranged the visit for 27 November 2017. On the 13 November 2017, NHO1 became aware of a letter signed by Gordon requesting the appointment be changed to Friday 10 November 2017. However, it was too late to respond to. NHO1 did not receive this note until after completing the 27 November 2017 visit.

14.5.15 On 27 November 2017, NHO1 attended Gordon's home and was seen in the property by Jane. NHO1 heard movement upstairs and asked Jane whether Gordon was coming down. Jane said Gordon was not in and that her son was upstairs. We know that Jane did not have a son. Jane explained that Gordon was visiting his sister who was described as being on her death bed.

14.5.16 NHO1 believed the heating had not been on for some time, as the house was very cold. The conditions were poor, the carpet was thread-bare and there were no cushions on the base of the couch. It appeared someone had been sleeping on the couch as evidenced by the presence of a sleeping bag. NHO1 explained the need to rearrange the visit so Gordon could be seen.

14.5.17 Jane's defensiveness, mannerisms and persona made NHO1 uneasy. NHO1 left feeling something was not right and contacted Stockport Homes' Fraud department about her concerns that Gordon was not present at the property on either visit and that it was in a poor condition. The Fraud Team suggested to NHO1 that the benefits Gordon was receiving seemed incompatible with his active independent lifestyle described by Jane.

14.5.18 NHO1 sent a written appointment to Gordon for 8 January 2018.

14.5.19 On 7 January 2018 Jane voluntarily disclosed to the police what she had done.

14.5.20 The panel felt that while it was not ideal that Stockport Homes had not seen Gordon for 12 years it was the vigilance of NHO 1 that brought the homicide to light.

Department for Work and Pensions

14.5.21 In January 2018 Jane/Gordon were receiving the following allowances.

Jane		
Allowance Name	Weekly £	Annually £
Carer's [for look after her disabled elderly father]	62.70	3,260.40
Income Support [for looking after her disabled elderly father]	44.50	2,314.00
Gordon		
Allowance Name	Weekly £	Annually £
State Pension	146.06	7,595.12
Pension Credit	18.52	963.04
Attendance [as a disabled pensioner and being cared for by his daughter Jane]	55.65	2,893.80
Totals	£327.43	£17,286.36

Note: This equalled £1440.53 monthly.

14.5.22 As is now known these fraudulent claims amounting to about £189,000, were the subject of criminal charges. The Department for Work and Pensions require claimants to notify them of any changes that would affect their entitlement. Jane did not make any such notifications and continued claiming the full allowances until she disclosed Gordon's homicide. She seems to have lived a modest life and at the time of disclosing her crime had outstanding balances on store cards and no known savings.

14.5.23 In 2009 the Department for Work and Pensions wrote to Gordon asking if there were any changes to report in his income. A reply was not received and the Department assumed that there were no changes to report and payments continued at the same rate into the same accounts.

14.5.24 The current process for the Department for Work and Pensions is to write annually to the customer to ask if there are any changes in circumstances and if no reply received then payments continue as normal. If the claimant is required to provide further information then a letter is sent, followed up by a telephone call and if no response, a home visit will be requested. It is

reliant on the next of kin to notify the Department when a claimant has died through the 'Tell us Once' process where one telephone call to the local authority will then inform all relevant agencies of the death so benefit payments will cease.

14.5.25 There is no record of Gordon having an occupational pension.

14.5.26 The panel felt there were no realistic reason or opportunity for any agency to have identified Jane as a perpetrator of domestic abuse. All the evidence discovered after the homicide indicates she was a victim.

14.6 Term 5

What enquiries did you agency make to ascertain whether Gordon needed services, who were they made to and what was your response to the replies?

14.6.1 This term has largely been addressed under terms 1 to 5 above. The medical agencies attended to Gordon's modest health requirements and offered him annual flu jabs while the Department for Work and Pensions continued paying him and Jane five separate allowances. Stockport Homes offered current tenancy visits, winter welfare visits; and it was this regime that probably lead Jane to disclose Gordon's homicide to the police. In that respect the service was effective.

14.7 Term 6

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Gordon, Jane and Sarah?

14.7.1 Gordon, Jane and Sarah were white British with English as their first language. The Department for Work and Pensions recognised the needs of Gordon and Jane as illustrated by the range of supportive allowances they received.

14.7.2 Stockport Homes took account of Gordon's needs through it winter visits policy and while age is not of itself a diversity issue, the practice of completing these visits, will identify people with diversity requirements.

14.7.3 The GP offered annual flu jabs which is a recognition of the additionally vulnerability faced by people aged 65 or over who contract flu.

14.8 Term 7

What learning has emerged for your agency?

General Practice

14.8.1 The individual management review notes: '...with the benefit of hindsight, there might have been a missed opportunity to consult with Gordon in person to ensure that he had indeed written this letter himself, that his

capacity was indeed intact and that his decisions were not being made under any form of duress'.

Stockport Homes

14.8.2 Stockport Homes had already tightened up its checks during current tenant visits and insist on seeing the tenant. This led to a more assertive approach being taken during late 2017, when the Neighbourhood Housing Officer insisted on seeing Gordon despite excuses made by Jane. It was the continuing improvement programme of Stockport Homes that introduced winter welfare checks and an insistence that the tenant was seen. NHO1's persistence probably lead to Jane's crime being uncovered.

DHR Panel

14.8.4 The panel felt this tragic case exemplified what is already known about the hidden nature of domestic abuse and sexual abuse within families. The disclosure barriers faced by Jane were likely to be representative of the well-established reasons why victims do not say what is happening. Therefore, the challenge to Stockport Safer Partnership is to ensure that the advice, guidance and support available to victims and the public, assists victims to overcome barriers to disclosure and provides the public with a pathway to obtaining advice should they know or suspect that such abuse is happening within families.

14.8.5 Had Jane felt able to disclose what was happening to her, the events of January 2006 may not have taken place. After Gordon's death Jane was likely to have faced a financial barrier to disclosure because the benefits she was receiving would have stopped.

14.9 Term 8

Are there any examples of outstanding or innovative practice arising from this case?

14.9.1 The panel recognised that NHO1's diligence probably lead to the discovery of the homicide and recognised it as good practice.

14.10 Does the learning in this review appear in other domestic homicide reviews or safeguarding adult reviews commissioned by the Safer Stockport Partnership or Stockport Safeguarding Adults Board?

14.10.1 The manager of Safer Stockport Partnership and Stockport Safeguarding Adults Board report that the learning from this domestic homicide review was not replicated in other reviews save for one domestic homicide review [DHR7] which identified additional cultural barriers to disclosure of domestic abuse.

15. CONCLUSIONS

15.1 Gordon was born at the end of World War 1, fought in World War 2 and was decorated for his service. He married following demobilisation and after fathering three children, separated and divorced in around 1968/69. His wife formed another relationship but died when she was relatively young from natural causes. Gordon did not remarry, nor is it thought, formed any enduring relationship. He retired from the computer manufacturing industry and settled into a quiet life, seemingly enjoying gardening and photography.

15.2 Jane was Gordon's youngest child and after her marriage broke down, she and her daughter Sarah returned to live with Gordon in the house she was brought up in.

15.3 Jane's brothers had long left the family home by then and they only had spasmodic and infrequent contact with Gordon and/or Jane. The same was true of Jane's former husband Brian.

15.4 There is evidence from family members that Gordon was a controlling and coercive person and expected those in his home to do as he said. Robert recalls arguments between his parents and cups being thrown. The domestic abuse was not known outside of the family and only surfaced in 2018 after Gordon's homicide was discovered.

15.5 There was a report from a former work colleague after Gordon's death, that he took and kept what amounted to an indecent photograph of a young woman he claimed was Jane and showed it to several workmates.

15.6 It is now known from Jane that Gordon: sexually, physically and mentally abused her as a child and an adult and that these criminal acts were not reported to the police or any other agency. The death of Jane's mother removed a possible line of support for her.

15.7 The reasons for Jane's long-term depression were never established; the symptoms were treated without the cause being identified. Her reported self-harm might have had the same root cause as her depression.

15.8 Jane experienced 40 years of sexual abuse from Gordon since she was five. She reported being raped hundreds of times and used as a sex slave. Jane said when she was aged somewhere between six and nine, Gordon took her to a photography club where he forced her into indecent poses while other men took photographs of her.

15.9 The abuse continued up to Gordon's homicide. He would constantly touch Jane's breasts even as she entered her fifth decade. She said she had no friends, no hobbies, had never worked and only rarely left her home town during her whole life.

15.10 The strain of a lifetime of sexual abuse for Jane ended when she killed Gordon after finding indecent photographs of a young girl. The trial judge is reported as saying, 'Her rational judgment was impaired and she was unable to exercise self-control'. He added that, 'he did not believe Jane would ever

have confessed had the net not started to close in around her. A representative of Stockport Homes had become suspicious of Gordon's whereabouts and was due to make a house visit the day after Jane confessed.

15.11 The barriers faced by Jane to disclosing her lifetime of abuse were so great that she was not able to do so until months after she was charged with Gordon's murder. The panel was in no doubt that Gordon's sexual abuse of Jane had a deep and lasting impact on her and was the precipitating event in Gordon's homicide.

15.12 The fact that Gordon's homicide remained undiscovered for 12 years and the accompanying benefit fraud are not the focus of this review. The opportunities to discover the homicide were tangential and realistically no opportunities were missed. The homicide of Gordon was not a failing of agencies.

16. LEARNING IDENTIFIED

16.1 Agencies

16.1.1 Agencies learning appears at Section 14.8 of the report.

16.2 Domestic Homicide Review Panel

16.2.1 The panel did not identify any learning that was not already known to domestic abuse professionals; the findings reinforced existing learning. A significant feature of this case was the depth and longevity of domestic and sexual abuse suffered by Jane at the hands of her father and the unsurmountable barriers she faced to disclosing her experiences. This point is covered in the single recommendation made by the panel.

17. RECOMMENDATIONS

17.1 Agency Recommendations

NHS Stockport Clinical Commission Group [for General Practice]

17.1.1 When a person opts out of care and that opt out seems out of character the administrator receiving that opt out should liaise with the practice safeguarding lead.

17.2 Panel Recommendations

1. That Safer Stockport Partnership reviews it current strategy to ensure that it provides the best opportunity to victims of familial domestic and sexual abuse to disclose their victimisation and identifies how it can best advise members of the public what to do if they know, or suspect, such abuse is happening.

Appendix A Action Plan

No	Recommendation NHS Stockport Clinical Commission Group	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	When a person opts out of care and that opt out seems out of character the administrator receiving that opt out should liaise with the practice safeguarding lead.	Training for administrative employees at GP practices to raise awareness & curiosity – cascade learning through GP adult leads briefing	Minutes of adult leads briefing	Admin staff will have received training & will have confidence to flag concerns to safeguarding leads.	Sarah Martin/James Higgins	November 2018
No	DHR Panel					
2	That Safer Stockport Partnership reviews it current strategy to ensure that it provides the best opportunity to victims of familial domestic and sexual abuse to disclose their victimisation and identifies how it can best advise members of the public what to do if they know, or suspect, such abuse is happening.	Develop a clear and easy to follow pathway for Domestic Abuse and ensure it is shared widely.	Documented pathway.	Members of the public and professionals with have a clear understanding of how to report Domestic Abuse and what support services are available.	Nuala O'Rourke	March 2019

End of overview report