SETDAB | Southend, Essex & Thurrock Domestic Abuse Board

Domestic Homicide Review
Overview Report

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

Southend Community Safety Partnership

A Review into the death of Linda in April 2021

Report produced by Joanne Majauskis

Date 10th March 2022

Southend Community Safety Partnership

Preface

This is a Domestic Homicide Review Report referring to the life and death of "Linda" and the suicide of "Michael". These are pseudonym's chosen by Linda's family and will be used throughout this report.

This tragic event resulted in the loss of two lives which has left their families devastated. I would like to begin by expressing my sincere sympathies, and that of the panel, to the family and friends of "Linda" and "Michael". We appreciate the input from them during this difficult process.

This review is into the death of Linda however much of the information contained within it will focus on Michael as this is the information that agencies held. The author did not wish for Linda to become a 'footnote' in the review and therefore asked Linda's sister to provide some words of tribute about her beloved sister:

> "Linda was an intelligent and attractive lady. She took care of herself, and no one would have guessed her age at 67. She was a practical person, always cheerful and resilient, who was good at making the best of things. She was looking forward to better days ahead and her life should never have ended in the way that it did. Prior to her retirement she had a long career in the Civil Service. Well thought of by her colleagues, she was good at mentoring new staff and prided herself on providing a helpful service to the public.
>
> Linda liked needlework, reading and gardening and kept up to date with current affairs. She loved going on holiday, preferably places with beautiful and natural scenery. She was never bored with her own company, but also enjoyed socialising with close friends and family and was a much-loved Auntie.
>
> Married to Michael at just 19, he was always her number one priority. No one could have supported him more or tried harder to resolve his health issues and I know she would be devastated at the anguish and grief caused to both families by his actions.
>
> Linda was my precious sister, my only sibling – I loved her dearly and I miss her every day."

The review was commissioned by the Southend Community Safety Partnership on receiving notification of the death of Linda in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004. It follows the guidance set out by the Home Office.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address the issues that it has raised. I would like to thank all those who contributed.

Contents

Section One - Introduction

1. Introduction

1.1 This Domestic Homicide Review report examines the circumstances surrounding the death of Linda, a 67-year-old female and resident of the Southend Community Safety Partnership area. She was killed by her husband, Michael, in the home they shared, in April 2021, he then took his own life.

1.2 The primary purpose of a Domestic Homicide Review (DHR) is to enable learning. In order for the learning to be shared as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly what needs to change in order to reduce the risk of such tragedies happening again in the future.

2. Summary of circumstances leading to the review

2.1 This Domestic Homicide Review (DHR) has been conducted in accordance with statutory guidance under Section 9 (1) of the Domestic Violence, Crime and Victims Act 2004.

2.2 This report was commissioned by Southend Community Safety Partnership (SCSP) under the centralised process agreed by the Southend, Essex and Thurrock Domestic Abuse Board (SETDAB).

2.3 The circumstances of the death of the victim fulfil the criteria of Section 9 (3)(b) of the Domestic Violence, Crime and Victims Act 2004 in that the homicide was carried out by a spouse.

2.4 This is a murder/suicide case, it is believed that Michael shot his wife Linda before shooting himself. Michael was a registered firearms licence holder with access to firearms.

3. Confidentiality

3.1 The findings of this review are confidential. Information is available only to participating professionals and their line managers until the review has been approved by the Home Office. Following approval, the report should be shared appropriately within and between organisations in order to disseminate the learning.

3.2 Before the report is published the Southend, Essex and Thurrock Domestic Abuse Board (SETDAB) Domestic Abuse Team and Southend Community Safety Partnership will circulate the final version to all members of the review panel, the Police, Fire and Crime Commissioner for Essex, the DA Commissioner's Office and family members. The family will be notified of the publication date.

3.3 To protect the identity of those involved the following pseudonyms have been used throughout this report:

"Linda" and "Michael". Linda was 67 years old at the time of her death and Michael was 71 years old.

4. Terms of Reference

Statutory Guidance (Section 2.7) states the purpose of the DHR Review is to:

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

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

4.3. Apply these lessons to service responses including changes to policies and procedures as appropriate.

4.4. Prevent domestic violence/homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter- agency working.

4.5. Contribute to a better understanding of the nature of domestic violence and abuse and highlight good practice.

Specific Terms of Reference

4.6 This report of a Domestic Homicide Review will consider relevant past agency contact and involvement with Linda and Michael and in particular will focus on the time from September 2017 until the time of the incident. At this time Michael suffered a significant health issue which appears to be the start of ongoing health problems which form part of this review.

4.7 The independent chair agreed the Terms of Reference for the Review with the panel. The family were also consulted and added to the themes that were considered. The key issues identified were:

- What processes are in place when renewing a shotgun license, are spouses/family members included in this process?
- We understand from the family that Linda was trying to get help for Michael for his mental health, do we know what help and from whom?
- Do G.P.s do any assessment on quality of life/impact on mental health for people with long term ill health?
- We understand that Linda and Michael were in the process of changing the G.P. surgery, what was the reason for this?
- Was it usual for Michael to contact the G.P. by letter?
- Did Michael and Linda have any financial issues that could have been a contributing factor?
- Was isolation a factor and specifically was the pandemic a factor in isolation and accessing healthcare?
- Were there any signs, signals or concerns regarding domestic abuse or coercive controlling behaviour? If so, how was this addressed?

4.8 Agencies completing Individual Management Reviews (IMRs) were required to analyse these issues in relation to their contact with Linda or Michael, with specific reference to:

- What policies, procedures and guidelines provide the framework for the agency's response to the above issues.
- What training is available to, and accessed by, staff in relation to responding to the above issues.
- What communication should have taken place between agencies in relation to the above issues; whether this took place; the quality and outcomes of that communication.

5. Methodology

5.1 Essex Police notified SETDAB and the Southend Community Safety Partnership of the homicide on 2nd June 2021.

5.2 The Domestic Homicide Review Core Group met to discuss the case on 6th July 2021 and considered the circumstances of the case, with the assistance of thorough scoping from relevant organisations. A decision was reached that the homicide met the criteria for a Domestic Homicide Review (DHR) and an Independent Chair, Joanne Majauskis, was appointed to carry out the review.

5.3 Where it was established that there had been contact, agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members.

5.4 Agencies that were deemed to have relevant contact were asked to provide an Individual Management Review (IMR) and a chronology detailing the specific nature of that contact. The aim of the IMR is to look openly and critically at individual and organisational practice to see whether changes could or should be made to agency policies and practice. Where changes were required then each IMR also identified how those changes would be implemented.

5.5 A partnership workshop was held on 10th December 2021 to consider the case and capture key issues for this report.

5.6 Information from records used in this review was examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the review is to prevent a similar crime.

5.7 This review began in July 2021 and was concluded in March 2022. Reviews should be completed, where possible, within six months of commencement. The Review was completed as quickly as possible while allowing time for family and friends to read and comment on the report. There were some delays in the information gathering process due to back-logs and some delays were experienced due to agencies being required to divert resources to respond to Covid-19 pandemic.

6. Involvement of family, friends, and wider community

6.1 An introduction to members of Linda's family was made by Police Family Liaison Officers, who passed a letter to Linda's sister and brother-in-law introducing and setting out the purpose of the review, the letter included the Home Office prepared leaflet for family and friends, as well as details about Advocacy After Fatal Domestic Abuse (AAFDA).

6.2 Michael's family, his brother and sister-in-law, were also invited to take part in the review and information regarding the review was forwarded to them. Michael's sister-in-law (his brother's wife) then made contact with the chair by telephone.

6.3 Linda's sister initially responded via the Police Family Liaison Officer to say that she did not wish to be involved in the review as she had been devastated by the incident. However, she later wrote to the chair highlighting her feelings, concerns and asking for the review to consider the following:

- The impact of being unable to see a G.P. in person.
- The pandemic and the impact lockdown had on people's mental health.
- An "urgent review of rules regarding the issue of gun licenses".

6.4 Following the workshop, it was felt by the panel that the gun club where Michael was a member may be able to provide some useful insight. The chair spoke by telephone with the club secretary, who was also a friend of Michael's having known him for twenty years and who, prior to Covid-19, would see him on a weekly basis.

6.5 The points raised by both families were discussed at the panel meeting and have been reflected on in the analysis section of this document. The input from Michael's associate is also discussed in the analysis section of this report.

6.6 The Chair would like to thank the families and the club secretary for their engagement and the contribution that they have made to this review. It has been invaluable and has helped significantly in our understanding of Linda and Michael's relationship.

6.7 Linda and Michael's family were both provided with a copy of the report before it was concluded to allow them to consider this in private and without time pressures.

7. Contributors to the Review

7.1 The following agencies contributed to this Review through submitting a chronology and Independent Management Review (IMR):

- Essex Police
- Southend Clinical Commissioning Group/G.P. Surgery
- Southend Hospital

8. Review Panel

8.1 The panel for this review was selected to represent the agencies involved but also organisations that would bring the requisite specialist knowledge to the review. All the panel members, IMR authors and summary report authors were independent of any direct interaction with Linda or Michael.

Joanne Majauskis	Independent Chair and Author	
Michelle Williams	SETDAB Domestic Abuse Coordinator	SETDAB Domestic Abuse Coordinator
Val Billings	SETDAB Domestic Abuse Coordinator	SETDAB Domestic Abuse Coordinator
Simon Ford	Head of Community Safety	Southend Community Safety Partnership
Gemma Robinson	Community Safety Strategy and Insights Manager	Southend Community Safety Partnership
Sharon Connell	Designated Lead Nurse Safeguarding	NHS Southend Clinical Commissioning Group (CCG)
Alice Faweya	MSE Named Nurse for Safeguarding Adults	MSE Hospital Trust Representative
Tendayi Musundire	Associate Director for Safeguarding	Essex Partnership University NHS Foundation Trust (EPUT)
Deborah Payne	Named Professional Quality and Governance	Essex Partnership University NHS Foundation Trust (EPUT)
Lynn Scott	Head of Adult Social Care	Southend Adult Social Care
Sarah Range	Head of Quality Practice and Principal Social Worker	Southend Adult Social Care
Paul Hill	Business Manager	Southend Safeguarding Adults Board
Jules Bottazzi	Head of the Strategic Vulnerability Centre	Essex Police
Sarah Conlon	CEO	Safe Steps
Paula Blundell	CEO	South Essex Advocacy Service

9. Domestic Homicide Review Chair and Overview Report Author

9.1 The Southend, Essex and Thurrock Domestic Abuse Board appointed Joanne Majauskis as DHR Chair and Overview Report Author in July 2021.

9.2 Joanne is an independent consultant and trainer with fifteen years' experience working in the Domestic Abuse Sector. Joanne has experience of working both in frontline and strategic management roles. Joanne has also Lectured for the National Centre for the Study and Prevention of Violence and Abuse (NCSPVA) at the University of Worcester having completed her Masters in Dynamics of Domestic Violence with Distinction in 2015.

9.3 Joanne completed Independent Domestic Abuse Chair Training with Advocacy After Fatal Domestic Abuse (AAFDA). AAFDA is a Centre of Excellence for Reviews after Fatal Domestic Abuse and for Expert and Specialist Advocacy and Peer Support.

9.4 Joanne has been working independently for two years and is not employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

10. Parallel Reviews

10.1 There were no criminal trials during this review process.

10.2 An inquest was carried out and a copy of the coroner's bundle was requested but never received. Linda's family shared some of the findings from the inquest that they felt pertinent with the chair.

11. Equality and Diversity

11.1 The nine protected characteristics in the Equality Act 2010 were assessed for relevance to the Review. The following characteristics were not felt to be relevant: disability, gender reassignment, pregnancy and maternity, race, religion and belief, sexual orientation.

11.2 Michael and Linda were both White British.

11.3 Linda was 67 years old at the time of her death and Michael was 71 years old. They had been married for 45 years.

11.4 Age as a protected factor was considered in this case. The possibility that Linda and Michael may have been isolated due to retirement was discussed. It is also noted that there are specific barriers facing older people in accessing services such as health services. In its paper, 'Breaking Down the Barriers: Older people and Complaints about Health Care' the Parliamentary and Health Service Ombudsman concluded that, "It is clear that older people can find it hard to know how to raise a concern or a complaint and feel less confident to push for what they need."

11.5 In this case, the pandemic played a factor as it had a significant impact on older people given that they were considered to be more vulnerable to the virus. This led to many older people being unable to leave their homes and becoming increasingly isolated.

11.6 In order to ensure that age as a factor was given sufficient consideration, a member of South Essex Advocacy Service was invited to join the panel. South Essex Advocacy Service is an independent advocacy support service for isolated, excluded and vulnerable adults in Southend where Linda and Michael resided.

11.7 Gender is significant and should be given consideration in all Domestic Homicide Reviews. Gender is considered a risk factor as the overwhelming majority of victims of domestic abuse are female with the perpetrators being overwhelmingly male. Statistics show that the majority of intimate partner homicides are disproportionately perpetrated by men on women (ONS, 2020).

12. Dissemination

The following have reviewed the report in draft form, and/or will receive a copy (or notification) of publication:

- The family of Linda
- The family of Michael
- Senior managers of all participating agencies
- Workshop attendees
- Southend Community Safety Partnership
- Southend Essex and Thurrock Domestic Abuse Strategic Board
- The Office of Police, Fire and Crime Commissioner
- The DA Commissioner's Office

Section Two - The Facts

13. Introduction to the Facts of the Case

13.1 In April 2021 a friend attended the home of Linda and Michael having not had the usual contact with Linda. When she arrived, the car was on the drive and keys were in the front door. She phoned the landline and when no-one answered she used the keys to enter the property where she found Michael. She called for 999 and when the ambulance arrived, they also discovered Linda with two shotgun wounds to her head.

13.2 Linda and Michael had been married since 1972. They were retired and had no children.

13.3 There is no evidence to indicate a history of domestic abuse. To the contrary, their families state that they had a happy and loving marriage. Members of both Linda and Michael's family expressed surprise and concern that a Domestic Homicide Review was being conducted as they did not feel this was an issue.

13.4 Michael was a registered firearms certificate holder for over thirty years; he was first issued a licence in 1988. His latest licence was valid from 2017-2022.

13.5 Michael was struggling with his health in the lead up to the incident. In September 2017, Michael was hospitalised following a ruptured right common iliac aneurysm. An iliac aneurysm is a bulge and weakness in the wall of the iliac artery, found in the pelvis. When iliac aneurysms burst, it can cause life-threatening, uncontrolled bleeding. This appears to be the start of ongoing health problems for Michael.

13.6 Between October 2019 until March 2021 Michael had numerous contacts with his G.P., Southend University Hospital and a private healthcare provider for ongoing health issues.

13.7 Michael was previously of good health. Prior to his health issues he was a keen cyclist and enjoyed an active lifestyle.

13.8 On 4th March 2021, Michael wrote to his G.P. about his health issues. Michael ended the letter by saying, "I can't go on living like this. If my digestion was sorted out, I could live a normal life again. I hope you can help me".

13.9 It is of note that the incident happened following a year of living with the pandemic. This will have had a significant impact on the response of services and people's ability to access them. It is also widely reported that lockdown caused many people's mental health to deteriorate.

14. Chronology

14.1 This chronology covers the period from September 2017 up to the date of the homicide/suicide.

14.2 There was very little agency contact with either Michael or Linda. The only information regarding Linda was held by the Southend Clinical Commissioning Group (CCG) for routine health visits. Most of the information contained in the chronology relates to Michael's health, which forms a significant part of this review.

Combined chronologies

14.3 6th September 2017 – Michael is admitted to the Intensive Care and High Dependency Unit at Southend University Hospital following a ruptured right common iliac aneurysm. He was discharged home on 18th September 2017.

14.4 12th October 2019 – Michael attends the Accident and Emergency Department at Southend University Hospital. He presents with lower limb pain to his left leg which is radiating to his thigh, shortness of breath and tingling hands.

14.5 15th October 2019– Michael is seen at the Cardiology Department following an episode of atrial fibrillation (an irregular and very rapid heart rhythm) whilst on a cruise. He reported feeling tired for two days whilst on the cruise ship and could not manage stairs initially and then go beyond six yards without experiencing breathlessness. Michael was seen by the cruise doctor on 14th June 2019 and found to have fast atrial fibrillation. An echocardiogram (ECG) was performed at the hospital.

14.6 11th October 2020 –Michael is taken to Southend University Hospital by ambulance having had a nosebleed for over two hours. Michael reported that the bleeding was spontaneous whilst riding his bike.

14.7 27th November 2020 – The hospital records email correspondence from the MRI department to the consultant advising that Linda had called to say Michael did not wish to have the MRI scan, this was cancelled.

14.8 8th January 2021 – Michael attends the Accident and Emergency Department at Southend University Hospital. He presents with bloating, weight loss, poor appetite and diarrhoea for the last few days. At this time, he had a known, large, incisional hernia. Diagnostic procedures and a CT scan showed this to be non-malignant but suspect gastroenteritis. It is recommended that Michael follow up with his G.P. if his symptoms continue.

14.9 3rd February 2021 - Michael attends the Accident and Emergency Department at Southend University Hospital. He presents with abdominal pain, gastroenteritis, palpitation,

intermittent abdominal bloating, reduced appetite and weight loss. Michael also reports he had collapsed due to feeling dizzy and nauseous. It was noted that the MRI had been declined and a plan to restart a previous dose of anticoagulant was recommended.

14.10 5th February 2021 – Michael attends a cardiology appointment.

14.11 4th March 2021 – Michael writes to his G.P. to ask for a referral to a gastroenterologist for constipation. He had been seen by a consultant in early 2021 and investigations had been undertaken all being clear, it was thought the problem was due to a hernia. However, Michael was having continued problems and stated he thought the hernia looked worse. Michael says in his letter that the use of laxatives does not agree with him and restricts his ability to go out of the home due to lack of public toilets. Michael ends the letter by saying, "I can't go on living like this. If my digestion was sorted out, I could live a normal life again. I hope you can help me".

14.12 23rd March 2021 – Linda and Michael register with a new G.P. surgery.

14.13 26th March 2021 – The G.P. has a telephone consultation with Linda (with Michael's consent). Michael is reported to have been unwell for the past three months. Linda states that approximately six weeks previously Michael started to develop brain fog, palpitations, a tight chest and difficulty breathing. Following the consultation, the G.P. requests screening bloods and an ECG.

14.14 30th March 2021 – Michael is seen at the G.P. surgery, his ECG and blood tests are all normal. This is his last contact with the surgery.

Section Three - Overview and Analysis

15. Summary of Information known to Agencies, Family and Friends

15.1. The overview will summarise information provided by the agencies, family and friends during the period under review.

Linda's Family

15.2 Linda's sister said that Linda and Michael had a long and happy marriage, and he was never violent prior to this tragedy. She describes Linda as a devoted wife who "could not have looked after him better".

15.3 The family report that following Michael's aneurysm in 2017 and then a succession of further "traumatic" health related issues, Michael's physical health diminished. They said this was very upsetting to him as prior to 2017 he had enjoyed the best of health.

15.4 Linda's family said that Michael became unwell again, in late December 2020, with digestive problems, breathlessness and a racing heart. Despite seeking help from his G.P., hospital visits, and attending private healthcare no one could get to the root of the problems. The family state that as a consequence of his physical health, Michael became very anxious.

15.5 Linda's sister said they felt that Michael was clinically depressed, and they believe he may have even had undiagnosed Post Traumatic Stress Disorder relating back to his aneurysm in 2017.

15.6 She stated that close friends and family were aware of Michael's physical health issues and were very supportive, often in touch by phone, asking about his progress. However, due to the pandemic lockdown, visitors were not allowed so none of them realised how severely his mental health had declined.

15.7 Linda's sister said that Linda and Michael did not feel they were getting a good response from their G.P. She stated that they had told her that the G.P. was unresponsive to letters and refused to see Michael, so on advice from family they made the decision to change surgeries.

15.8 The family report that Michael was still going for bike rides (using an electric bike), purchasing items online and doing some gardening. Although they were aware he was "low", Linda had assured them that with a new G.P. on side she was hopeful that both his physical and mental health would improve, and he would be back to his usual self.

15.9 They family stated that Linda had said that Michael would be "loathe to ever mention feeling anxious to his G.P." as this would have caused difficulties with him continuing with a hobby he enjoyed (shooting).

15.10 The family concluded that they felt Michael was overwhelmed by the thought of more medical tests and decided he could no longer go on but felt he could not leave Linda behind to cope without him. They stated that "no-one would ever know what was going on in Michael's head" and that Linda "certainly did not know what a dark place he was in".

15.11 Linda's sister stated that they feel that the impact of the pandemic combined with Michael's mental health issues were significant factor in their deaths.

Michael's Family

15.12 Michael's sister-in law (his brother's wife) said Michael had been suffering from depression for some time due to his physical health issues. He had previously been very active and now couldn't do the things he used to. She stated that towards the end, he wouldn't even make eye contact with people.

15.13 Michael's family state that they had the "perfect retirement". They had no money worries and used to holiday every month before the pandemic. They said that right up until the end Linda was still booking weekends away (where they were accepting a refundable deposit if cancelled).

15.14 They felt Michael's physical and mental health issues had been exacerbated due to the pandemic. They report that Linda had been trying to get help for Michael's mental health as it was getting worse but felt that the "G.P. was rude and dismissive". They said this had prompted Michael to seek private health care due to not feeling like he was getting the help he needed.

Club Secretary from Michael's Gun Club

15.15 Michael's friend and shooting colleague stated he had known him for many years. He said that prior to the pandemic he would see Michael most Saturdays. However, at the time of the incident the club had been closed for over six months due to Covid-19 restrictions, so he hadn't seen him, although they did stay in touch by email.

15.16 He stated that he was aware of Michael's physical health issues, but that Michael always appeared to be his "jovial self" and there did not appear to be any mental health problems.

15.17 Michael was an active member of the club but had resigned as treasurer of the club last year due to ill health, citing stomach problems. The club secretary said that Michael would have hated to let anyone down.

15.18 The Gun Club has policies and procedures to follow if they note any concern with members. Part of this is to contact police to advise them of these concerns. The club also has regular contact with the police firearms team who visit the club but at the time this had also ceased due to Covid-19.

15.19 The club secretary concluded that the Gun Club members are a close community with a culture for looking out for each other. He believes that had the club been open they may have noticed a decline in Michael's mental health and taken appropriate steps to support him.

Southend University Hospital

15.20 Linda had three contacts with Southend University Hospital in 2014/15. They were all for oral and maxillofacial (jaw and face) related issues after a lump was identified on the inside of Linda's cheek and removed.

15.21 Michael was admitted to hospital on 6th September 2017 with a ruptured right common iliac artery. Michael was taken to theatre for repair of the ruptured aneurysm and transferred post-operatively to the Critical Care Unit. He remained an inpatient before being discharged on 18th September 2017.

15.22 Between October 2019 until February 2021 Michael made six visits to the hospital, five of which were to the Accident and Emergency Department, presenting with a variety of complaints. These visits are detailed in the chronology.

Primary Care Medical Centres

15.23 Linda and Michael both accessed their G.P. practice for routine and symptom-specific physical health issues.

15.24 The G.P. recalls the couple being frequent communicators, with there being, at certain time periods, daily telephone calls. Linda rarely contacted the G.P. on her own behalf, however, she did write and telephone the surgery about Michael's physical health.

15.25 There is very little information held in Linda's health records. She mostly accepted standard health screening appointments, including blood tests and routine treatment offers such a flu

and COVID-19 vaccinations. There is not any single event, diagnosis or issue recorded in her care summary record to indicate that she was anything other than an older woman who was aging well.

15.26 The medical records show that Michael had a history of heart problems and remained prescribed two medications to manage the condition, which may have caused him some physical health side effects, though this is not noted within the Care Summary Record.

15.27 The Care Summary Record shows that Michael accessed his G.P. infrequently prior to 2020, but that after that contact "snow-balled".

15.28 The IMR acknowledges that the speed at which matters escalated is of note in relation to this event. From November 2020 Michael presented multiple times with minor physical health symptoms such as dizziness, nosebleed and loose stools, and as a result of these he underwent a wide range of examinations and tests.

15.29 The Care Summary Record shows that the tests and examinations Michael underwent were largely inconclusive but ruled out anything significantly wrong with his physical health. It is also noted that Michael sought two private consultations in February 2021 but that these too were inconclusive with plans for follow-up appointments.

Essex Police

15.30 The Essex Police criminal investigation following the tragic events of April 2021 concluded that Linda had been killed by Michael who then took his own life; there were no other persons involved.

15.31 Research conducted post-incident established that with the exception of firearms licensing, Essex Police had no involvement with Linda or Michael during the period subject to review.

15.32 Michael was a licensed firearms holder for over thirty years having first been issued a licence by Essex Police in 1988. His firearms licence and his suitability to possess a firearm form the main focus of the police IMR.

15.33 The Essex Police Firearms, Shotgun and Explosives Licensing Department (FSEL), based at Police Headquarters manage all aspects of firearms and explosives licensing. The department is located centrally at Chelmsford, but covers all of the Essex Police District, including the unitary districts of Thurrock and Southend.

15.34 The activity of the FSEL is governed by Firearms Legislation, Home Office Guidelines, Authorised Professional Practice (issued by the College of Policing) and Essex Police Policy and Procedure. Policy and Procedure are reviewed annually, and changes made where appropriate.

15.35 Certificates are only granted where the Chief Constable is satisfied a person:

- has a good reason to possess a firearm, shotgun and ammunition.
- has the ability to store them securely.
- has the intention to use them reasonably and lawfully without endangering public safety or the peace as required by the Firearms Act 1968 and 1997.

15.36 On initial application, and again at the point of renewal, the FSEL undertake a number of checks and enquiries aimed at determining an applicant's suitability. These vary dependent upon a number of factors including whether it is an application to grant a certificate or an application to renew an existing certificate application. The checks/enquiries include some or all of the following: police intelligence and database checks, medical enquiries, enquiries with referees, interviews with applicants and storage and security inspections.

15.37 Firearms and shotgun certificates are subject of renewal every five years during which the suitability of the individual to possess their weapons is assessed continually. Processes are in place to notify FSEL where a certificate holder comes to police notice. Notification may also be made where a certificate holder's medical circumstances change. Where notified FSEL will further assess the individual's suitability. Where necessary weapons can be removed whilst assessment takes place.

15.38 The current process to acquire a firearms certificate requires the applicant to provide personal details, details of the firearms they wish to hold and details of the storage and security arrangements in place. It also requires the applicant to stipulate the purpose for which the firearm is required, for example, target shooting. In the case of target shooting the applicant must show they are a full member of a Home Office approved gun club, which Michael was.

15.39 Applicants must also supply information relating to their general health and include their G.P. contact details, with authority for Essex Police to contact the G.P. and obtain factual details of the applicant's medical history. It is made clear to the applicant that there will be an ongoing onus on their G.P. to notify Essex Police of any qualifying conditions that the applicant may consult their G.P. about. This applies throughout the time the certificate is in place.

15.40 In 2021, at the time of the fatal shooting, the weapons specified on Michael's certificate included shotguns, pistols and rifles. In addition, he was licensed to acquire and keep a quantity of explosives. This was gun powder of a type and quantity consistent with the licensed firearms on his certificate. The shotguns owned by Michael were of a type outside of the standard shotgun definition and defined in law as Section 1 Firearms. Therefore, all the weapons held by Michael, including those described as shotguns, were licensed and held under a Firearms Certificate.

15.41 Michael held a variety of different weapons over the years, periodically making applications to vary the firearms held or notifying FSEL regarding transfer or disposal of a gun. In April 2021, there were fifteen weapons listed on Michael's certificate.

15.42 Under Section 44 of the Firearms (Amendment) Act 1997, a person wishing to possess a rifle or muzzle-loading pistol (Section 1 Firearms) solely for target shooting must be a member of an approved rifle club or an approved muzzle-loading pistol club. Section 44(1)(b) requires an approved club to be specified on the firearm certificate. Michael was a registered member of an approved club, and this was detailed on his firearms certificate.

15.43 Michael's licence was last renewed in March 2017 (four years before the deaths) and was valid until 2022. The requirement to ensure an individual is suitable to hold a licence applies equally at renewal as it does at the point of initial application. However, where initial checks confirm there has been no change in circumstances (since the licence was issued) it may not

be necessary to complete the full range of enquiries originally undertaken at the time of issue.

15.44 It is a condition of any certificate issued that the holder notify Essex Police should they begin to suffer from a relevant medical condition, having sought medical advice or treatment for a condition whilst a certificate is in place.

15.45 The relevant medical conditions that must be disclosed are:

- Acute Stress Reaction or an acute reaction to the stress caused by trauma
- Suicidal thoughts or self-harm
- Depression or anxiety
- Dementia
- Mania, bipolar disorder, or a psychotic illness
- A personality disorder
- A neurological condition: for example, MS, Parkinson's or Huntingdon's disease, or epilepsy
- Alcohol or drug abuse
- Any other mental health or physical condition which might affect the safe possession of a firearm or shotgun

15.46 Michael submitted his application for renewal to Essex FSEL on 10th December 2017. Part B of the application includes a medical declaration, which he had duly completed to confirm that he did not suffer with any relevant medical conditions. He also signed the application providing consent for Essex Police to contact his G.P.

15.47 Michael confirmed in his application that he had not been convicted of any offence or received a written caution. The application included a signed declaration confirming the information provided was true and acknowledging that it is an offence under Section 28 A (7) of the Firearms Act to knowingly or recklessly make a false statement.

15.48 The declaration includes the following:

> I understand that I am expected to inform the police if I begin to suffer from a relevant medical condition, having sought medical advice or treatment for such a condition, while the certificate remains valid.

15.49 FSEL contacted Michael's G.P. by means of the standard letter to advise that he had been granted a firearm/shotgun certificate. The letter asks the G.P. to respond confirming three things. Firstly, whether they have any concerns about the applicant being issued with a shotgun/firearm certificate. Secondly, to confirm whether or not the applicant suffers with any of the relevant medical conditions. Thirdly, whether they have placed a shotgun/firearm reminder alert on the patient's record.

15.50 There is an entry on the National Firearms Licensing Management System (NFLMS) completed by Essex FSEL to show the G.P. letter was sent on 16th December 2017. There is no entry to indicate that the G.P. responded to the letter.

15.51 Between 2017 and 2021 Michael submitted five variation applications. This is where he wished to vary the firearms listed on his certificate. Some applications were to acquire an additional weapon, other applications included both acquisition and notification of intention to dispose of a weapon. On each of the applications to vary Michael ticked the box to say he

had not been diagnosed with or treated for any of the relevant medical conditions.

15.52 At no point between 2017 and 2021 did Essex Police FSEL receive contact from Michael, his registered G.P. or anyone else to indicate that he may be suffering from any relevant medical condition or that there had been any change in his medical circumstances (physical or mental) which might affect his safe possession of a firearm or justify FSEL making further enquiries.

15.53 It is noteworthy, that in 2016/17, at the time of Michael's renewal, a process of automatically renewing firearm and shotgun certificates had been introduced due to significant backlogs. This was based on completion of background checks and an assessment of risk. On completion of the necessary checks, those applicants deemed to be low risk were contacted by telephone and asked a series of security and health questions. If no further risks were highlighted a new certificate was issued.

15.54 Michael's application was, therefore, subject only to an initial assessment before his certificate was re-issued to him in March 2017. Due to his previous history of full compliance, unblemished record, and absence of both any known police intelligence and relevant medical conditions he was considered low risk.

15.55 At this time, FSEL had also ceased making home visits for renewals that were assessed as being suitable for a telephone renewal.

15.56 Full background checks were not subsequently completed until October 2017, with these confirming Michael was, 'Grade C – No concern or significant change in circumstances.' He was assessed as low risk with final sign-off taking place in February 2018 and the certificate issued in March 2017 remaining in place.

15.57 In 2017, as with the current process, where a certificate was issued a post-issue letter was sent to the applicant's G.P. to alert FSEL should the holder present with any relevant medical condition.

15.58 In January 2018, a peer review was conducted of Essex FSEL process by the Metropolitan Police Service (MPS). In their findings, they reported that the assessment of risk was being sacrificed at the expense of clearing the backlog of renewals. The MPS recommended to Essex Chief Officers that the auto-renewal process should cease in favour of a return to home visits. Additional resource and funding were subsequently allocated to FSEL.

15.59 The learning from 2016/17, led to a revised risk-based approach to deal with future periods of demand. This was fully developed and approved by Chief Officers in October 2019. It is the process which currently operates within Essex Police. It is in line with current Home Office guidelines.

15.60 Furthermore, since April 2020 all applications for the renewal of a shotgun/firearms certificate must be supported by a Medical Screening Report (MSR) completed by the applicant's G.P. or another company providing that they have a registered GMC doctor.

15.61 The completion of the MSR serves a number of purposes. Firstly, it encourages applicants to make full and proper medical disclosures within their application to FSEL, knowing that their G.P. will be independently submitting an MSR.

15.62 Secondly, it makes the G.P. aware of a patient's application and provides opportunity for the G.P. to inform FSEL of any relevant medical information, which may impact upon the applicant's suitability to hold a certificate.

15.63 Thirdly, the MSR requests that the G.P. surgery places a 'Firearms Read Code' (also referred to as an Alert Code) on the applicant's patient record so that, during the lifetime of the firearms certificate, should the applicant develop one of the 'Relevant Medical Conditions' the G.P. is able to notify FSEL.

16. Analysis

16.1. This part of the review will examine how and why events occurred. It will consider whether different decisions or actions may have led to a different course of events. The analysis section considers the previous sections within this report, the content of the IMRs, and the chronology of events.

16.2 This review is not looking into the cause of Linda's murder but seeks to address the terms of reference. The purpose of the review is to examine the contact Linda and Michael had with services and analyse whether those services were appropriate and whether there are lessons to learn from this tragedy, including identifying good practice.

16.3 As with the chronology, most of the analysis in this review pertains to Michael. Whilst this is a review into the death Linda, there is very little information held by agencies about her. Most of the information that is available for the panel to consider relates to Michael's health and his firearm licence.

16.4 Due to the limited amount of information originally available to the review, the original Terms of Reference contained questions that the panel wished to explore. Subsequent information provided in the IMRs and by the family mean that these did not become a significant part of the review. These are addressed below:

Did Michael and Linda have any financial issues that could have been a contributing factor?

16.5 This was raised as there was a lack of information regarding the couple's finances. Financial issues are a known risk factor in domestic homicide cases and in suicide cases (Roscoe et al, 2020; Bond and Holka 2018; Saxby and Anil 2012). Benbow (2019) also identified financial issues as a particular theme in domestic homicides whereby the victim and/or perpetrator were above the age of sixty. However, in this case it was confirmed by Linda's family that Linda and Michael had no money worries. They could afford to go on regular holidays and opted to pay privately for health care in an attempt to resolve Michael's health care issues.

Were there any signs, signals of concerns regarding domestic abuse or coercive controlling behaviour? If so, how were these addressed?

16.6 Previous history of domestic violence or abuse is always considered in these circumstances as research suggests that controlling behaviour is present in 92% of domestic homicides (Monkton-Smith et al, 2017). However, there is no information recorded in any of the participating agency files who came in to contact with Linda and Michael to indicate that there were any issues relating to domestic abuse prior to the murder. To the contrary, reports from family and friends portray Linda and Michael as a loving couple who had been happily married for 45 years.

16.7 In exploring the theme of domestic abuse, the hospital IMR identified that when Linda presented to Southend University Hospital due to a lump on the inside of her cheek, possible causes could have been explored as her condition could have been indication of a stress related disorder. Although this, in itself, is not an indication of abuse, the importance of professional curiosity is highlighted as an opportunity for potential victims to make a disclosure. This is addressed in recommendations.

16.8 It is also noteworthy, that when an application is made for a firearms licence, background checks are completed nationally and locally. Where there is information relating to domestic violence or abuse wider interviews are considered with a range of family, friends or associates of the applicant prior to issue or renewal of a firearm/shotgun certificate. Police would also work on intelligence reports that aren't criminal convictions to inform those discussions with family regarding any concerns. No such information was held regarding Linda and Michael. Although background checks act as a protective factor, we know that domestic abuse is often hidden and remains unreported. This was discussed by the panel and consideration was given as to whether spouses and family members should be asked routinely. Contributors to the panel said this is not done routinely in case it escalated a situation if a licence was refused after an interview with a victim. In the case of Linda and Michael this would have been unlikely to change the outcome. However, there is clearly a risk attached to a firearm being in the home of an unidentified victim of abuse and this is considered in the recommendations.

Thematic Analysis

16.9 The remaining questions raised in the Terms of Reference were grouped into three main themes for analysis: the licencing of guns; Michael's physical and mental health and the impact of the pandemic. These are discussed below.

Shotgun Licence Procedures

16.10 The discussion on the issuing and ownership of firearms formed a large part of this review. In particular, the procedures for renewing shotgun licences, the monitoring of licence holder's mental health and barriers to licence holders disclosing declining mental health.

16.11 Linda's family hold strong views regarding this subject, and these have been taken into consideration as part of this analysis. Specifically, they felt that firearms should not be kept in the home. They also felt that five years was too long for a review, given that people's mental health can decline quickly, in Michael's case it would appear to be a matter of months.

16.12 However, it is important to note that Michael was a licenced firearm holder for over 30 years without incident. It was clearly a hobby he loved and a big part of his life.

16.13 Essex Police state that they "recognise and uphold individual's qualified rights to possess firearms and ammunition in accordance with current legislation. The Force is committed to facilitating gun ownership, whilst maximising public safety through the application of checks, enquiries and inspections designed to ensure licences are only issued to fit and proper persons in line with legislation and Home Office Guidance."

16.14 It is significant to this review that new statutory guidance for Chief Officers of police on firearms licensing came into effect in November 2021. This has brought about changes for assessing the medical suitability of applicants. It will ensure that no one is granted a firearms certificate unless their doctor has confirmed to the police whether or not they have any relevant medical conditions, including in relation to their mental health. Essex Police has already implemented the medical element of the new statutory guidance which now requires a response from the G.P. However, even if this had been in place at the time of the murder it is unlikely that this would have altered the outcome in this case given that the G.P. was unaware of the decline in Michael's mental health.

16.15 The guidance incorporates the 2019 Memorandum of Understanding agreed between the British Medical Association (BMA), the National Police Chiefs Council (NPCC) and the Home Office (HO) regarding the notification of relevant medical information relating to shotgun and firearms certificate holders. The Memorandum of Understanding sets out the roles and responsibilities of police and doctors regarding the medical assessment of firearms applicants and the ongoing monitoring of those in possession of a firearms certificate.

16.16 In 2017 when Michael renewed his licence a standard letter was sent to inform the G.P. The letter required the G.P. to disclose whether they had any concerns about Michael being issued with a shotgun/firearm certificate and whether or not he suffered with any of the relevant medical conditions. It also asked the G.P. to confirm they have placed a shotgun/firearm reminder alert on his record.

16.17 The Essex Police IMR identified that the G.P. letter was sent December 2016, it asks for a response within 21 days, but there is no entry on the FSEL system to indicate that the G.P. responded to the letter. This was raised in the panel meeting, with the CCG confirming that they have no record of receiving the letter. It was pointed out that the only letter the G.P. surgery had on file, in relation to the firearms license was back in 2012. This breakdown in communication is clearly a concern although it was felt that even if the letter had been received and responded to it would have made very little difference to the support provided and ultimate outcome of this case. Furthermore, this would not happen under the new guidance which requires a Medical Screening Report as discussed in 15.60-3.

16.18 However, there is no requirement for a G.P. to proactively monitor or assess a patient who holds a firearm certificate, although there is a duty on them to disclose

information where they believe the patient may present a risk of death or serious harm to themselves or others.

16.19 This may only happen, therefore, following a disclosure from the patient, yet information shared to this review suggests that the fear of having his firearms licence removed may have prevented Michael from disclosing or help-seeking to his G.P. A statement provided to police by Linda's sister post-death, states:

> "[name of husband] and I were both very shocked to see Michael in this state. When we got home, I sent a long text to Linda, saying I was concerned about his mental health, and I suggested she asked the new G.P. for something to help with his anxiety. She texted back that Michael had said that he had been pleased to see us both and felt that we were empathetic. She said that they did not want to mention anxiety to the G.P. as this could impact on Michael's gun licence and one of the things he was looking forward to getting back to was his hobby of shooting. She said that she felt sure that once his physical health improved then so would his mental state."

16.20 In order to remove barriers to disclosure of mental health issues, Essex Police FSEL, through targeted media work, promote that mental health is not an automatic barrier to certification. It seeks to inform certificate holders that the police work together with medical professionals and treat each case on its own merits. The objective is to encourage and support certificate holders suffering with mental health to contact their G.P.s and obtain the help they need. Had this message been clearly conveyed to Michael, it may have given him confidence in being able to approach his G.P. about how he was feeling without fear of losing access to his hobby.

16.21 Essex Police FSEL also report that they work closely with partner agencies, including local G.P. Clinical Commissioning Groups, to highlight the risks of suicide within the shooting community and encourage full disclosure by doctors. In October 2021 Essex Police FSEL participated in a Suicide Prevention Workshop, involving G.P.s and medical professionals, at which FSEL gave a presentation and shared a Firearms and Mental Health awareness leaflet which has been produced for distribution to certificate holders in Essex.

16.22 The presentation made to G.P.'s and Healthcare Professionals highlights current firearms legislation, the role of FSEL and the current reporting requirements. It seeks to further improve partnership working and information sharing between agencies.

16.23 In addition to encouraging disclosure from licence holders and G.P.s, gun clubs also play a role in monitoring their members. Clubs supply non-attendance lists to FSEL to highlight members who have not been active. Firearms certificates justification for holding a certificate must be provided, this is often cited as membership of a target shooting club, so non-attendance is relevant. Non-attendance may also be an early indicator of declining health, especially in older members, and therefore forms the basis of further enquiries by FSEL staff.

16.24 Michael's associate from the gun club collaborated (15.18) this saying that clubs have a duty to disclose inactive members but also to report any concerns regarding a member's mental health.

16.25 Essex Police FSEL report that they seek to promote good relationships with local gun clubs, dealers and others involved in the shooting community. Often those relations are fostered over many years. This enables gun clubs to pass on information where club members or organisers have concerns about an individual.

16.26 In this case, FSEL was not notified that Michael was a non-attender, nor were any specific concerns raised regarding his physical or mental health. However, this was due to the fact that the period of time in question was affected by Covid-19 restrictions which impacted upon normal gun club attendance for members.

16.27 The panel also discussed the issue of information sharing with regard to knowledge of individuals who hold firearm licenses and the sharing of disclosures of mental health issues, or other concerning issues relating to firearm certificate holders.

16.28 The discussion regarded which organisations would be aware of someone's firearm licence. For example, if an individual had a firearm marker on their G.P. records this information would not necessarily be available if they presented to A&E with a mental health crisis. Locally speaking, it was clarified that a majority working in health have access to 'System One' which would show this information (whether that's full access or read only), however, not all hospital settings have access to this. In this situation, an A&E attendance report would go back to the person's G.P. who would then have oversight and ownership. There are added complexities when an individual travels across borders to a different area, and vice versa.

16.29 Adult Social Care confirmed they have flags on their system, and should they become aware of a firearm, all practitioners involved in a case would take note of that. They clarified that if they received a disclosure of a firearm, they would also liaise with Essex Police to ensure it is licensed.

Physical and Mental Health

16.30 Michael's health is a significant theme in this review. Family input gives an insight into the impact that Michael's physical health had on his mental health. Previously of good health, his ongoing health concerns had a significant impact on his quality of life and prevented him from engaging in hobbies and activities he enjoyed.

16.31 Linda's family felt that Michael was clinically depressed and suspect he may have even had undiagnosed Post Traumatic Stress Disorder (PTSD) following his aneurism in 2017. In an analysis of DHRs whereby the victim and/or perpetrator were above the age of 60, Benbow et al (2019) found that major mental illness of the perpetrator, drug and/or alcohol abuse, financial issues and a history of domestic abuse were all key themes.

16.32 Frustration at not being able to get to the bottom of his health issues led Michael to seek out private healthcare and change G.P. surgeries. The change to private healthcare may account for the cancelled MRI appointment mentioned in 14.7. Linda's sister says she feels Michael was overwhelmed by the thought of more medical tests and believes this led him to feeling "he could no longer go on, but that he could not leave Linda alone to cope without him."

16.33 It was discussed by the panel whether G.P.s would enquire about a patient's mental health if they had ongoing physical health concerns. It was clarified by health colleagues during the panel meeting that Michael was not diagnosed with a debilitating illness and in fact all of the tests that Michael underwent were inconclusive. That coupled with the fact that because of the pandemic Michael was not having face-to-face appointments meant it was unlikely this would have happened. It is also unclear, even if enquiries had been made if Michael would have made a disclosure due to his concerns about having his firearm licence revoked.

16.34 Initial reports stated that the family had said that Linda was trying to get Michael help for his mental health, however, this was not evident from any of the reports from healthcare. It is also apparent that family/friends knew his mental health was suffering but that no-one seemed to have realised the extent.

16.35 The panel also discussed the possibility of whether Michael did in fact have physical problems or if it was necessary to explore whether his presentations for physical health issues were a subconscious cry for mental health support. However, it is evident that Michael seemed to be looking for a physical diagnosis and there is a strong belief that he would not have accepted a suggestion of anything other than physical health concerns.

16.36 The first and only time there was any indication, outside of the family, that Michael's emotional wellbeing was in anyway impacted was in the letter Michael wrote to the G.P. on 4th March mentioned in 13.5 and 14.11. From the Primary Care Medical Centre IMR, we know that this letter was filed on 17th March and there is no evidence that it was acted on.

16.37 It was at this time that Linda and Michael were transferring to the new G.P. surgery. This would have commenced an electronic medical record and access transfer process that would have 'deducted' them from the patient list at their old surgery. Whilst it is recorded in the Care Summary Records that this change from one practice to another happened simultaneously on the 23rd March 2021 there would have been a time lag between commencing the process and completing it that is entirely an administrative process. This may provide some explanation for why Michael's letter went unanswered. Input from the CCG at the panel meeting suggests that at the point of receiving the letter, the G.P. would not have had an opportunity to have an appointment with Michael to discuss his concerns.

16.38 Around this time, Michael also completed a new patient questionnaire for registering at the new practice, and this did not contain any reference to his emotional wellbeing.

16.39 Michael was last seen on the 26th March 2021 at the new surgery, a short time before the incident occurred. The record of the consultation did not reflect that the medical practitioner thought Michael's mental state was in any way impaired, let alone to the degree he was potentially homicidal and/or suicidal.

16.40 It is not possible to know if the subsequent course of events would have been any different if the letter had been acted upon. However, it is clearly a missed opportunity to enquire about Michael's mental health. Given that the other time the couple wrote a letter to the G.P., in November 2020, it resulted in a telephone consultation, it is reasonable to conclude letters from patients are not routinely filed without action. This has been, therefore, recognised as an error which is acknowledged by the surgery. This is discussed further in the conclusions and recommendations.

Impact of the Pandemic

16.41 It is important to acknowledge that at the time of the incident in April 2021 the Covid-19 pandemic was at its height in terms of impact on day-to-day life in England. It is widely reported that the pandemic had a detrimental impact on some individual's mental health, particularly older people (McKinlay, 2020; Ipsos Mori, 2020) and it was felt by family members and by Michael's associate that the pandemic was without doubt a factor in this tragedy.

16.42 Michael's family report that Linda was very proactive in her attempts to keep Michael safe and well and wouldn't allow visitors as she was concerned about his health. Both families also report that lockdown, in addition to Michael's poor health, meant that he was isolated from his usual activities.

16.43 Although it is impossible to say in hindsight, those known to Michael felt that they may have been in a position to recognise Michael's deteriorating mental health and intervene had they been having their regular and usual pre-pandemic contact.

16.44 Research also highlights the issues people were faced with when trying to access healthcare (McKinlay, 2020; Ipsos Mori, 2020). During the time considered by this review, most services had, in response to Government directives, switched to virtual formats wherever possible and G.P. surgeries were no exception to this. High levels of staff sickness and unprecedented level of patient needs meant that Primary Care had to operate under extremely pressured circumstances. In-person appointments were not the automatic format for consultations as had been the case previously.

16.45 It is unclear how I.T. literate both Linda and Michael were, however, their Care Summary Records showed they were not averse to telephone, SMS Text Message and paper letter forms of communications. We cannot know whether a face-to-face appointment would have meant that Michael's declining mental health would have been recognised or if this would have changed the outcome.

Section Four – Lessons Learnt

17. Conclusion

17.1 This tragic loss of two lives has left their families devastated. It can never be known whether different actions would have resulted in a different outcome, but we hope that the lessons learnt, and the changes made as a result of this review are able to give them some comfort in that others will be better protected. Our thoughts are with both families.

17.2 There was little information available to the panel, but certain themes emerged that are addressed here and in the recommendations.

17.3 Whilst it can never be known with complete certainty, there was no evidence to suggest that, prior to the tragic incident, there was any violence or abuse in their relationship. To the contrary, family narrative suggests a long and loving marriage.

17.4 Family anecdotes also paint a picture of a formerly fit, healthy and active man whose life had become limited due to health issues. The limitations on life imposed due to the pandemic had added to this. These two things prevented him from pursuing his usual hobbies of cycling and shooting.

17.5 There was nothing in the information known to Essex Police that could or should have alerted them to the changes in Michael's physical or mental health, or to the risk that he posed to Linda and himself. Particularly, given that Michael had held his licence for over 30 years without incident.

17.6 The Review did not identify any missed opportunities by the Force to safeguard Linda or to prevent Michael's actions, such as would have changed the tragic events of April 2021. However, it does highlight the link between mental health and the risks associated to firearms ownership.

17.7 The risks of firearm possession are well understood by police and the possession of firearms in the UK is subject to a robust national licensing framework. Recent updates to the guidance and legislation underline the critical importance of ensuring effective disclosure of medical information between certificate holders, G.P.s and firearms licensing departments.

17.8 Linda's sister had strong thoughts on the ownership of firearms and gave permission for them to be shared in the report: "It would be my wish that guns are never allowed to be legally stored in anyone's home. But I recognise that bringing in such a measure would never even be considered, never mind passed, due to strong opposition from gun club members. It is ironic that 'Michael' was a vociferous campaigner against the changes bought in following the Dunblane massacre – saying it was an over the top, unnecessary, knee jerk reaction taken against legitimate gun licence holders. Yet when his mental health declined, look at the tragedy that occurred…and which could have been avoided if he was not allowed such easy access to lethal weapons in his own home. But I suppose we must be grateful that we do not live in the USA, that we do at least have a gun licensing authority and that the flagging of medical records has been reviewed and improved recently."

17.9 Essex Police state that they are already working with partners and certificate holders to reduce barriers to reporting and encourage information sharing. New statutory guidelines should serve to further strengthen the requirement for G.P.s to have effective monitoring and reporting processes in place.

17.10 The new guidance requiring Medical Screening Reports removes the reliance on the certificate applicant declaring their current and/or past medical issues and allows police to have factual medical information which should help reduce the potential risk of that individual having a firearm or shotgun certificate.

17.11 We can speculate that in some cases, as appears here, that the ownership of a firearm or shotgun licence can be a barrier to a disclosure of declining mental health. This is one of the main learning points from this review. Further work with certificate holders, gun clubs and the wider shooting community must be encouraged to enable certificate holders to reach out and seek help, even where it may impact on their ability to hold a firearm.

17.12 The discussion regarding disclosure of information also highlighted the issue of how agencies share information. Currently there is a reliance on either a disclosure from the licence holder or from the G.P. regarding mental or physical health conditions. However, it may be possible

that other agencies hold relevant information about the licence holder that may affect their suitability to hold a licence.

17.13 Furthermore, a firearm licence holder may be working with services who would benefit from knowing that they are in possession of a firearms licence so that they can assist in the monitoring of that individual and to inform their own risk if, for instance, they are conducting home visits.

17.14 This review also highlighted the importance of professional curiosity and the opportunity for routine enquiry. NICE Guidelines state, "Professionals should maintain professional curiosity and questioning while building a good relationship". The SET Safeguarding Guidelines April 2019, states, "Professional curiosity is the capacity and communication skill to explore and understand what is happening within an adult rather than making assumptions or accepting things at face value. Professional curiosity can require practitioners to think 'outside the box', beyond their usual professional role, and consider circumstances holistically. Curious professionals will spend time engaging with adults. They will ask questions (in an open way) and seek clarity if uncertain and will be open to the unexpected".

17.15 The MSE Foundation Trust recognised in their IMR a potential missed opportunity to ask Linda about any experiences of domestic abuse when she presented with a condition that could have been stress related. There is no evidence of domestic abuse in this case, and it is doubtful that this would have resulted in a disclosure, however, routine enquiry in healthcare is promoted as best practice in the NICE guidelines.

17.16 The importance of asking about a patient's mental health when they are experiencing physical health issues over an extended period of time should also be considered. Michael's mental health declined over a period of time and does appear to be linked to his physical health issues. Of particular note, is the letter he wrote to his G.P where he alludes to his mental health. It is imperative that we employ professional curiosity and spend time communicating with individuals in order to understand them and their needs holistically.

17.17 Lastly, it is important to acknowledge the unprecedented circumstances the world was experiencing in the year leading up to the tragic event in April 2021. It is clear that the pandemic led to many people being isolated from both services and more informal support networks. Whilst we may never be able to understand what could have happened if that support was there, we can recognise that the loss of those networks is likely to have been a significant factor in this case, in particular when looking at isolation and an acute deterioration in mental health.

18. Recommendations

18.1 The guidance on the licensing of firearms has been thoroughly considered as part of this review. It is without doubt that recommendations would have been made here regarding the ownership of guns and the monitoring of mental health. However, new guidance and legislation on the licensing of firearms has come into effect since the Linda's murder and Michaels's suicide that has put more stringent measures in place and seeks to address the issues associated with the disclosures of medical conditions that could impact on an individual's suitability to possess a firearm.

Recommendation One:

18.2 Primary Care Practices to ensure all communications from patients and their significant others are responded to in an appropriate and timely manner. Guidance on timelines for responding to communications should be set out in policy and procedures. A self-audit of communications received should be completed by the practice involved in this review and sent to the Head of Safeguarding to have an overview and allow them to share any learning from this exercise on a wider scale.

Recommendation Two:

18.3 CCG to provide training to G.P.s on the importance of professional curiosity, with a focus on routine enquiry about mental health for individuals presenting with poor physical health, particularly where that has a significant impact on their quality of life.

Recommendation Three:

18.4 Mid-South Essex NHS Foundation Trust to review safeguarding and domestic abuse training to promote good practice when asking about domestic abuse. In particular focusing on the importance of professional curiosity.

18.5 In response to this review the Mid-South Essex NHS Foundation Trust has reviewed and rewritten their Domestic Violence Policy to provide clear guidance to staff on selective or routine domestic abuse enquiry and the use of professional curiosity and challenge.

Recommendation Four:

18.6 Firearms Suicide Prevention Workshops are already being conducted by Essex Police. Essex Police to widen the range of participants to include other healthcare professionals and multi-agency groups involved in safeguarding Domestic Abuse victims and protecting Vulnerable Adults. Thus, sharing the knowledge of the risks associated with mental health and the ownership of firearms and promoting links across agencies.

Recommendation Five:

18.7 Essex Police to form a working group with the relevant partners of Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board SETDAB to better understand if there is a method of providing firearms licensing information to agencies involved with persons in potential risk situations. *(This recommendation is repeated in another DHR underway)*

Recommendation Six:

18.8 The Home Office should initiate discussions to establish if the National Firearms Licencing System could be made available on a restricted basis to appropriate partners for the purpose of managing and mitigating risk. *(This recommendation is repeated in another DHR underway)*

Recommendation Seven:

18.9 The Home Office to consider a review of gun licencing protocols to include mandatory questioning of household members with the intention of managing the risk where there is unknown or undisclosed domestic abuse.

References

Benbow. S., Bhattacharyya, S., and Kingston, P. (2019) *Older adults and violence: An analysis of Domestic Homicide Reviews in England involving adults over 60 years of age* Ageing and Society, 39, 1097–1121.

Bond, N. and Holka, M. (2018) *A Silent Killer Breaking the Link between Suicide and Financial Difficulty* The Money and Mental Health Policy Institute

Ipsos Mori (2020) *The Experience of People Approaching Later Life in Lockdown* Centre for Aging Better

Home office (2021) Statutory guidance for police on firearms licensing

Mckinlay, A., Fancourt, D., Burton, A. (2020) *"It makes you realise your own mortality": A qualitative study on mental health of older adults in the UK during COVID-19* Research Department of Behavioural Science and Health, Institute of Epidemiology and Health Care, University College London

Monckton-Smith, J., Szymanska, K., and Haile, S. (2017) *Exploring the Relationship between Stalking and Homicide.* Project Report. University of Gloucestershire in association with Suzy Lamplugh Trust

Parliamentary and Health Service Ombudsman (2015) Breaking down the barriers: Older people and complaints about health care

Public health guideline (PH50) Domestic violence and abuse: multi-agency working. Published date:26 February 2014

Rosoce, H., Lindsay-Walters, F. and Fish, S. (2020) Analysis of Statutory Reviews of Homicides and Violent Incidents Social Care Institute for excellence

Saxby, P. and Anil, R. (2012) *Financial Loss and Suicide* Malays J Med Sci. 19(2): 74–76.

Statutory guidance for chief officers of police on firearms licensing - GOV.UK (www.gov.uk)

SET Safeguarding Guidelines April 2019 – Chapter 3.1