SETDAB Southend, Essex & Thurrock Domestic Abuse Board

Southend Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

Southend- on-Sea Community Safety Partnership

Rose died November 2023

Report completed May 2026

Report published July 2026

Chair and Author – Katie Bielec

Foreword

Rose, our sister was a kind person who spent her life looking after others, especially our mum, stepfather, elderly neighbours and friends. We all adored her for the angel she was.

Preface

Southend-on-Sea Community Safety Partnership, panel members and the author wish at the outset to express their deepest sympathy to the family of Rose. This review has been undertaken in an open and constructive manner with all agencies engaging positively which has ensured we have been able to consider the circumstances of Rose's death in a meaningful way and address with candour any issues raised.

Familial abuse is incorporated within the Domestic Abuse Act 2021[1] which introduced a statutory definition of domestic abuse to ensure a coordinated response from agencies:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—
"A" and "B" are each aged 16 or over and are personally connected to each other, and
the behaviour is abusive.
Behaviour is "abusive" if it consists of any of the following—
physical or sexual abuse,
violent or threatening behaviour,
controlling or coercive behaviour,
economic abuse,
psychological, emotional, or other abuse,
and
it does not matter whether the behaviour consists of a single incident or a course of conduct.

Section 2 of the Act provides the definition of "personally connected" which includes those who would constitute a "relative" of the victim. The definition of "relative" has the meaning given under section 63(1) of the Family Law Act 1996,[2] which includes immediate biological family, stepfamily and extended family of an individual, including such family members of their present or former spouse, civil partner or cohabiting partner.

Domestic Homicide Reviews became statutory in 2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004)[3], the Act states:

A Domestic Homicide Review should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:
a) A person to whom [she] was related or with whom she was or had been in an intimate personal relationship or
b) A member of the same household as [herself]; held with a view to identifying the lessons to be learnt from the death.

[1] https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted
[2] https://www.legislation.gov.uk/ukpga/1996/27/contents
[3] https://www.gov.uk/government/publications/the-domestic-violence-crime-and-victims-act-2004

1. Introduction

1.1 Rose (not her real name) was murdered by her brother Nick (not his real name). At the time of her death, they lived together in Southend with their elderly mother, Shirley (not her real name).

1.2 Due to Rose and Nick being personally connected, Southend-on-Sea Community Safety Partnership (CSP) identified the case met the criteria for a Domestic Homicide Review (DHR) as set out within the Home Office Multi-Agency Statutory Guidance for DHRs 2016[4].

1.3 Due to additional concerns regarding Nick's behaviour and relationship with Shirley and her husband (the siblings' stepfather), Shirley gave permission for the review to include her information to ensure a whole picture could be understood.

1.4 The review considered agency contact and/or involvement with Rose, Nick and Shirley from 1 January 2021 to the time of Rose's death. Agencies were asked to consider any events outside of these dates and include such information if relevant to the review.

1.5 This review examined agency responses and support provided to Rose, Nick and Shirley prior to Rose's murder. The report highlights positive and supportive practice, any barriers accessing services, and any learning that can be shared to reduce the risk of such a tragedy happening again in the future.

2. Glossary

2.1 **Athena** - A single integrated police IT system to manage police investigations, intelligence, custody, and case file management.

2.2 **AWARE** - A mnemonic created to help observe what is happening around a child: **A**ppearance, **W**ords, **A**ctivity, **R**elationships & **D**ynamics, **E**nvironment.

2.3 **DASH RIC**[5] –Domestic Abuse, Stalking and Harassment Risk Indicator provides a consistent way for practitioners who work with adult victims of domestic abuse to help identify risk of harm and manage their risk. Risk is determined into 3 categories:

- **Standard** - Current evidence does not indicate likelihood of causing serious harm.
- **Medium** - There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, e.g., failure to take medication, loss of accommodation, relationship breakdown and drug or alcohol misuse.
- **High** - There are identifiable indicators of risk of serious harm. The potential event could happen at any time, and the impact would be serious. A risk which is life-threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

[4] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

[5] https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL_1.pdf?msclkid=770463f4ceac11ec8f0466908e13260a

2.4 **GP** – General Practitioner a medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients.

2.5 **IMRs** - Individual Management Reports are provided by all agencies.

2.6 **SETDAB** - Southend, Essex & Thurrock Domestic Abuse Board.

2.7 **STORM** - A command-and-control database used by Essex Police to manage the deployment of resources and record incidents.

2.8 **Whole Family Approach -** Securing better outcomes for adults, children, and families by coordinating the support and delivery of services from all organisations.

2.9 **THRIVE –** This assessment model has been identified by the HMIC as best practice to assist operational staff to identify **T**hreat**, H**arm, **R**isk, **I**nvestigative opportunities, **V**ulnerability and **E**ngagement opportunities quickly and resolve issues at first contact.

2.10 **ACEs** -Adverse childhood experiences.

2.11 **LPA –** Lasting Power of Attorney.

2.12 **AWARE principles -**framework adopted by Essex Police to enhance professional curiosity to identify vulnerable children in child abuse and domestic abuse investigation.

2.13 **VOTC** – Voice of The Child.

3. Timescales

3.1 In November 2023, Southend-on-Sea Community Safety Partnership received a Domestic Homicide Review referral from Essex Police after Rose's murder. The decision to carry out the review and the commissioning of the chair and author was completed in December 2023. Initial scoping information was sought by SETDAB to ensure agencies were aware of the review.

3.2 Initially the aim for completion for the review was within six months of commissioning, to ensure it was in line with the statutory guidance (paragraph 46). However, this was not possible due to the on-going criminal case. As such, there was a delay in contacting the family and obtaining additional information from the police investigation. The family and all those involved with the review were kept informed throughout the process, with panel meetings held in March, July and September 2024.

4. Confidentiality

4.1 In line with paragraph 75 of the statutory guidance, to protect the identity of those involved and to comply with the Data Protection Act 1998[6] pseudonyms have been used throughout the report. The names Rose, Nick and Shirley were chosen by the family which were agreed by the panel.

[6] https://www.legislation.gov.uk/ukpga/1998/29/contents

4.2 Rose was 64 years old at the time of her murder; Shirley was 84 years old, and Nick was 54 years old. Both Rose and Shirley were/are female, and Nick is male. All identified as white British.

4.3 The sharing of information between agencies in relation to this review was underpinned by the SETDAB Information Sharing Protocol which is in place to facilitate the exchange of personal information and comply with Section 9 Domestic Violence, Crime and Victims Act 2004[7] .

4.4 Panel meetings were all confidential and any sharing of information to third parties was carried out with the agreement of the responsible agencies' representatives, the panel and chair.

4.5 All Individual Management Reviews (IMRs) are restricted to the authors, senior managers, and panel members. Information and findings have been included within the review and action plan. The final review and action plan has been agreed by the family, panel and Southend Community Safety Partnership and presented to the Home Office for final approval. Any initial learning identified has been acted on immediately.

5. Terms of reference

5.1 The family were provided the Terms of Reference for any comment with the support of their Victim Support Advocates.

5.2 Key lines of enquiry

- Consider how (and if there was knowledge of) familial abuse is understood by victims, family, friends, organisations, and the community.
- Determine if Rose and/or the family faced any barriers reporting risks and accessing support services, including:
  - The Equality Act 2010[8] protected characteristics
  - Possible learning difficulties
  - Mental ill-health
  - Familial abuse
  - Economic Abuse
- Review agencies responses, professional curiosity, interventions, care, treatment and or support provided to Rose, Nick and/or the wider family.
- Analyse whether the 'Whole System' and 'Think Family' approach was considered and applied especially with regards to familial abuse, conflicting issues within families with adult family children and carer needs.
- Consider whether the work undertaken by services was consistent with each organisation and local professional standards, domestic abuse and safeguarding policies, procedures and protocols and ensure adherence to national good practice.
- Review the communication between agencies, services, friends, family, and the community, including the transfer of relevant information.
- Examine services and agencies response to the welfare of any adults at risk of harm especially with regards to familial abuse.
- Consider if the COVID-19 pandemic impacted the health and wellbeing of Rose, Nick and/or the family as well as services provision and response.

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/97881/DHR-guidance.pdf
[8] https://www.gov.uk/guidance/equality-act-2010-guidance

- Highlight good and effective practice in response to Rose, Nick and/or the family.

6. Methodology

6.1 This review has followed:
- Home Office Multi-Agency Statutory Guidance for DHRs (2016).
- Domestic Violence, Crime and Victims Act (2004).
- SETDAB Domestic Homicide Review Protocol.

6.2 The panel identified agencies required to provide IMRs after SETDAB completed scoping across the Essex area. Agencies were provided with the Terms of Reference and asked to review their involvement with the family including discussions with staff (where appropriate). IMR authors were asked to highlight positive practice, any learning, recommendations, and actions ensuring these were quality assured and agreed by a senior member of staff.

6.3 Various pieces of research have been used and referenced throughout the report.

7. Involvement of family, friends, and colleagues

7.1 The Family Liaison Officer provided the family with a letter and Home Office leaflet, and who were also being supported by Victim Support Homicide Advocates. The chair remained in contact with the family and their advocates via phone, email and meeting in person throughout the process.

7.2 Rose worked at a local school. Both the school and the agency she worked for were contacted as part of the review and have provided memories of her.

7.3 No friends were identified for the chair to reach out and contact.

7.4 Neighbours who knew Rose, Shirley and Nick were elderly and had moved away from the area, which meant they were unable to be spoken to for the purpose of the review.

7.5 The chair spoke with Nick from prison with the support of his Custody Probation Officer.

8. Contributors to the review

8.1 SETDAB contacted over 40 agencies (including statutory and non-statutory services) across Southend, Essex, Cheshire and Chester. Of those the following agencies were identified to provide an Individual Management Review (IMR)[9]:
- Essex Police
- Rose's GP practice[10]
- Southend-on-Sea Council Adults and Communities (Adult Social Care)

8.2 IMR authors and panel members were all independent of any support or supervision of any agency interaction with the family.

[9] Barclays were not contacted.
[10] No GP registration could be found for Nick and the review was not able to obtain GP records for Shirley due to data protection and GDR restrictions.

8.3 The panel comprised of agencies recommended within the statutory guidance as well as specialist domestic abuse services. Panel members were required to review each IMR, provide feedback at meetings and support the process.

8.4 The panel consisted of:

Agency	**Role**
Bielec Consultancy Ltd	Chair and Author
Southend Community Safety Partnership	Head of Community Safety Community Safety Data & Insights Manager
SETDAB	Specialist Wellbeing & Public Health Officer Senior Domestic Abuse Coordinator
Essex Police	Detective Inspector - Head of Operational Development within the Strategic Vulnerability Centre
Southend-on-Sea City Council	Head of Prevention & Recovery, Southend Adults Social Care
Southend-on-Sea City Council and Police Crime Commissioner	Business Manager, Southend Safeguarding Partnership (Adults and Children).
NHS Mid & South Essex Integrated Care Board	Designated Lead Nurse Safeguarding
Essex Partnership University Foundation Trust (EPUT)	Clinical Nurse Specialist Safeguarding Practitioner Deputy Director of Nursing for Safeguarding and Mental Health Act.
Safe Steps (Domestic Abuse Service)	Chief Executive Officer

9. Chair and Author

9.1 Katie Bielec is an independent domestic abuse consultant, she is an accredited Domestic Homicide Review chair with AAFDA[11] and SILP[12], accredited MARAC[13] chair with SafeLives, has completed the Home Office Domestic Homicide Review Training, chairs MARMMs[14] and stalking clinics. She is an associate trainer for SafeLives, Rockpool, The Hampton Trust, a guest lecturer at Bournemouth University, published guest author of 'Social Work Practice with Adults – Transforming Social Work Practice' and accredited trainer delivering Coercive Controlling Behaviour and Stalking.

9.2 Katie was previously a Metropolitan Police officer working in a variety of roles, she is a qualified IDVA[15], IDVA manager, ISVA[16] Manager and managed domestic abuse services for 11 years. She is a member of AAFDA DHR Network, Standing Together Against Domestic Abuse Coordinated Community Response and The Employers Initiative on Domestic Abuse.

9.3 Katie is not associated in any way to any agency who have provided information or had any personal or professional involvement with anyone involved within the review.

[11] https://aafda.org.uk/
[12] Significant Incident Learning Process.
[13] Multi-Agency Risk Assessment Conference
[14] Multi Agency Risk Management Meetings
[15] Independent Domestic Violence Advocate, support for high-risk victims of domestic abuse.
[16] Independent Sexual Violence Advocate, support for victims of sexual violence/abuse.

10. Parallel Reviews

10.1 A criminal trial was held in May 2024. Nick pleaded guilty to murder and was sentenced to life in prison with a minimum term of 13 years. Due to the severity of the murder, the family believe this sentence was too lenient and that Nick will remain a danger to them and others.

10.2 Due to the outcome of the criminal trial the coroner concluded that Rose was unlawfully killed by Nick.

10.3 No other reviews were conducted at the time of this review.

11. Equality and Diversity

11.1 Rose was a 64-year-old white British female; Shirley is a white British Female and was aged 84 and Nick is a white British[17] male and was 54 years old at the time of the murder.

11.2 The Office for National Statistics (ONS) 2023[18] found that 73.5% of victims of domestic abuse were female. The Crime Survey for England and Wales estimated that 1.4 million women experienced domestic abuse between 2022 – 2023. Therefore, Rose was more likely to be abused due to being female. This pattern is also reflected in adult family violence, where women are disproportionately harmed by male relatives, partners, and ex-partners, particularly in contexts involving coercive control, financial dependence, or caring responsibilities. Gendered power dynamics shape both intimate partner abuse and abuse within family networks, meaning women face higher risks of serious harm across these settings.

11.3 In the year 2022 – 2023 the ONS found 4.2% of victims were aged between 60 – 74 years. Research from SafeLives and Dewis Choice[19] found people aged 61 years and over were more likely to experience abuse from an adult family member, than an intimate partner. The research also found that statutory services regularly did not recognise domestic abuse in cases where the perpetrator was not an intimate partner. This can then result in older victim-survivors not being offered access to specialist domestic abuse resources.

11.4 The family believe Nick thought that women were 'below' men, and they had a role to play within the home. This view of women did not match that of Rose who was independent, working full time and was in control of her money and able to be financially independent. This misuse of 'Male Privilege or Entitlement' is recognised within the Duluth research[20], such as reinforcing gender roles, withholding information, and misuse of medication, all of which appears to have been present within this home and ultimately became deadly.

11.5 Rose was diagnosed and had been on medication for Schizophrenia since 1991. She had 6 to 12 monthly physical and mental health reviews by practice nurses. No mental health or safeguarding issues were ever identified during these reviews, and Rose was managing her condition excellently. Her last nurse review was in August 2023.

[17] According to the latest 2021 census, the population in Southend-on-Sea is predominantly white (87%)

[18] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2023

[19] https://dewischoice.org.uk/wp-content/uploads/2021/12/Practitioner-guidance-document-English-epdf_compressed.pdf

[20] https://dewischoice.org.uk/wp-content/uploads/2021/02/Dewis-Choice-Duluth-Wheel-1.pdf

11.6 The family believe both Rose and Nick had a learning difficulty, however, neither were ever assessed as having one. Both attended secondary schools for children with additional learning needs but again there were never any formal diagnosis of this. The family recall how both Rose and Nick struggled academically and were unable to maintain friendships or relationships. Shirley and the family believed Rose was unable to live independently, and for the last 20 years of her life she lived with Shirley. Due to Rose never living on her own it is unclear if this was an accurate reflection or the family's perception.

11.7 Although Nick lived alone for some of his adulthood, he had lived with one of his sisters (and her family) as well as Shirley. He and the family informed the chair that he could never maintain a job and would 'flit' from job to job. He also struggled to understand the concept of boundaries within a family setting, believing that when there were consequences to his actions people were against him.

11.8 Even though there was no 'formal assessment' of a learning difficulty, if both Rose and Nick did struggle to understand the concept of boundaries, and how to communicate, it may have created additional barriers and complex dynamics within the family home. The charity, Choice Support[21], found those with learning difficulties are often treated as children, who rarely have a voice in decision making, leaving them invisible to agencies and those around them. They found those with learning disabilities were two times more likely to be subjected to domestic abuse, with abusers being more likely to be a carer or family member. They are less likely to understand they are being abused creating barriers in reporting to those around them or to authorities.

11.9 Neither Rose nor Shirley had or have any religious belief that influenced them day to day.

11.10 Nick informed the chair that in the late 1990's he was a practicing Mormon to '*get him off the drink'*. After six years he left the Mormon faith and did not practise any religion. He is now learning the Muslim faith in prison.

12. Dissemination

12.1 Rose's family and all agencies involved in the review are aware that the Overview Report and Executive Summary will be published once agreed by the Home Office. The action plan has already been disseminated to ensure immediate action and learning can be taken forward. All IMRs and other submitted report for the review will remain confidential and will not be shared.

12.2 Following agreement from the Home Office Quality Assurance Panel, Southend Community Safety Partnership will ensure the documents are disseminated to the family, Domestic Abuse Commissioner, the Police Fire and Crime Commissioner (PFCC) for Essex, all partner agencies and services represented on the panel and Probation /Prison Service ahead of publication.

12.3 The chair has worked closely with the family to ensure all key dates to avoid were considered with regards to publication. They have continued to be supported by Victim Support throughout this stage of the process.

[21] Choice Support | Domestic abuse

12.4 The family fears for their safety should Nick be released from prison. There is likely to be a significant amount of time from publishing the report and Nick's possible release. Therefore, the final report will be shared with the Victim Liaison Officer and Probation Practitioner as soon as it is published. A record will then be held on his notes that the family have asked for this report to be included within the Parole Dossier as part of the Victim Impact Statements.

12.5 The Overview Report and Executive Summary will be published on the SETDAB website[22].

13. The homicide

13.1 Shirely has lived in her 2-bedroom bungalow for 30 years; Rose had lived with her for 20 years and Nick, two years (before Rose's death).

13.2 The bungalow is situated in the corner of a quiet 'no-through' road, parking is available on the road and public bays. There is a small courtyard upon the entrance to the bungalow, to gain entry to this there is a wall approximately 4ft tall with a cast iron gate as you enter. The front door leads you directly into the kitchen with a door directly opposite leading to the living room. Off the living room is a small corridor to two bedrooms and a bathroom. There is also a small courtyard at the back of the bungalow which you can access from the living room.

13.3 During the evening of Rose's death, Shirley was in the living room watching TV and an argument started between Rose and Nick. During the argument Rose and Nick went outside to the front courtyard. Whilst outside there is evidence to indicate Nick assaulted Rose due to the injuries to her body. After assaulting her and whilst Rose remained outside, Nick went to the kitchen and selected a kitchen knife.

13.4 He then went into the courtyard of the bungalow and repeatedly stabbed Rose to the front and back of her body.

13.5 Nick called Essex Police reporting that he had been in a fight with Rose during which she had run into the knife he was holding, and that she was unconscious and appeared not to be breathing.

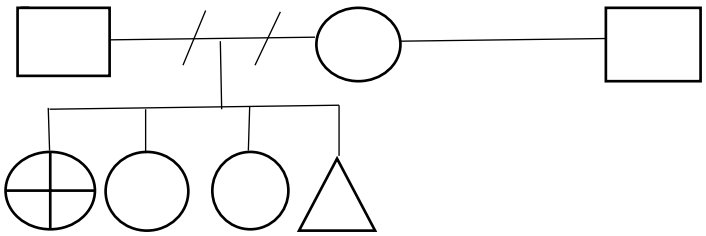
13.6 He then went into the living room and told Shirley that he had called the Police, repeatedly saying he was sorry.

13.7 Upon Police arrival, they found Rose in the front courtyard under some tarpaulin. Nick was initially arrested on suspicion of Grievous Bodily Harm. Paramedics attempted to save Rose's life but despite these attempts, Rose died a short time later. Nick was then further arrested for murder.

13.8 The defence solicitors requested a psychiatric assessment prior to the trial, this was completed and although the findings have never been shared, it was not used in his defence and in May 2024, Nick pleaded guilty to murder.

[22] https://setdab.org/

14. Genogram



Key

Rose

Nick

Female members of family

Shirleys husband

Divorced

15. Family and Relationship background – Information from family, friends and colleagues[23]

15.1 Rose was born to Shirley, who was aged 20 and living with her family in Yorkshire. Rose was the eldest sibling; she had two younger sisters and a brother (Nick). Shirley told the chair that she loved having her daughters but had always wanted a boy so was delighted when Nick was born.

15.2 Shirley divorced the children's father in 1980 when Rose was approximately 20 years old and Nick 10 years old. Shirley made attempts to obtain a restraining order against her ex-husband, although Rose's sisters do not recall this ever being granted. Both Rose's sisters do not remember any domestic abuse by their father and remember him as loving, would see them regularly, paid child maintenance and (as they got older) would take Nick on holidays, including going to Spain and on Safari.

15.3 Over the next decade Shirley had several relationships, which her daughters describe as abusive and controlling. One of these resulted in one daughter being asked to leave the family home and the other moving to another area once she married. Nick states he remembers domestic abuse within the family growing up and how this had a significant impact on his emotional wellbeing.

15.4 Rose's two sisters recall how Nick used to be the 'favourite' child; however, he would often hurt them by pinching and twisting their skin. When they cried, he would blame them, resulting in them being told off. He would also hurt the dog, but they remember his behaviour would be ignored and there were never any consequences.

15.5 Shirley told the chair that both Rose and Nick were "no trouble", would argue like most siblings and did not believe these or their relationship was anything unusual.

[23] Some family background has been included within the chronology to enhance the context of agency contact.

15.6 Due to their age difference, the two middle sisters were very close, while their relationship with Rose and Nick was more distant. However, they would always try to help each other.

15.7 Shirley married her second husband in the mid-1980's, and they moved to Ipswich. Just before they moved, they helped arrange Rose's wedding (It is unclear how Rose met her ex-husband). The sisters believe Shirley felt Rose was unable to live independently and wanted Rose married so she could live with her husband without Rose.

15.8 Rose moved to Warrington after her wedding and was married for approximately 10 years, this relationship was extremely abusive. Rose was domestically abused; her ex-husband would bring women into the home to have sex with them whilst Rose was in the house. She was not allowed to leave the house, her medication was withheld, was drugged with unknown substances and was physically assaulted. Rose was able to reach out to her family who travelled to collect her, when she returned to Southend, she moved in with Shirley (who had moved back to Essex with her husband) and divorced her abuser. The family informed the chair that Rose did not want to report the domestic abuse to Police as he had been incarcerated for drug offences, and she had moved away and felt safe.

15.9 Nick moved around the country; however, he spent two years living with his sister and her family (not Rose). She recalls he would run up large phone bills calling 'sex lines' and losing his keys. She told him he would have to pay for the phone bills and if he lost his keys, he would have to pay to have the locks changed. Nick started to tell Shirley that she was not treating him very well and making up stories. For example, that he was not allowed to use the bathroom and toilet. As a result, Shirley let Nick move in with her and her husband (and stepfather) for a very short period. Shirley's husband did not want him there as he was very unwell and required care.

15.10 At some stage the siblings inherited a sum of money, however, the family believe Nick spent his very quickly. He told them that he had invested his money but never explained what this was on, and they believe he may have been taken advantage of by people he was working with at the time.

15.11 Nick only had one girlfriend (known to the family); however, this did not last for very long. A few years before the COVID-19 pandemic he then moved to Chester where he was doing odd jobs and living alone. He would 'pop back' to Shirley's home, stay a while and then 'disappear' again.

15.12 After the death of Rose's stepfather (Shirley's husband) Nick moved back to Southend, unemployed and homeless. Shirley told the chair that she could not turn her son away so allowed him to stay but due to the bungalow having only two bedrooms, he slept on the sofa or on the floor in the living room.

15.13 Shirley told the chair she enjoyed having Rose live with her, and the neighbours also loved her as she would do anything for anyone. Rose would pay her 'weekly keep' (this is what Rose would call it). However, Nick was not working and therefore did not contribute towards the home. This caused friction between the two siblings. According to Shirley, she had told Nick to get a job, but he had told her they were difficult to find.

15.14 At some stage in 2023, Nick decided to rip out the bathroom. Shirley told the chair that she had been happy with her previous bathroom suite, however, Nick had insisted on

taking it out. Nick had no plumbing or building experience leaving Rose and Shirley with no toilet, bath, shower or sink. Rose was angry that he had done this, meaning they all had to wash in the kitchen. Nick hired a portaloo in the front courtyard and a commode for Shirley to use. The decision to take out the bathroom also created friction with the wider family.

15.15 Agencies involved within this review stated that with the information they held they did not envisage this murder happening. However, both Rose's sisters informed the chair they had always believed he was capable of harming one of them. He had evidently injured their stepfather, and they believed he had the capability to kill him. Once their stepfather had died, they were fearful he would kill either Shirley or Rose due to concerns for his mental-ill- health and general unusual behaviour.

16. Chronology[24]

16.1 In 2007, Nick attended the front office of a local Police Station reporting that he had been threatened by his stepfather and brother-in-law (not named). This was in the form of a note being left for him (where and when is not detailed within the report/log). He showed the handwritten note which was written in pencil. The note said 'Nick*, your sister will pick u up on Monday at 9 o'clock and take you to Queensway[25] please be there or we will inform the doctor'*.

16.2 The words *'inform the doctor'* had been rubbed out although still visible and had been overwritten in a different handwriting with, '*kill you'*. This in effect changed the context of the note. Nick went on to state that he was not taking his medication (it is not recorded what medication or what it was for). An incident was created, recording that Nick appeared to be suffering from mental ill health, was confused and was unable to provide an explanation as to why family members should want to harm him. He was advised to contact his GP and that should he have any further problems, to call the Police. It was determined that there was no further action to be taken, and the incident was closed.

16.3 Ten years later in 2017, one of Rose's sisters recalls attending Shirley's home and seeing her stepfather (who was 95 years old at the time), in bed with black eyes and covered in bruises. When she asked him about how they happened, he disclosed that Nick had punched him repeatedly whilst he was asleep. When Shirley was asked, she told her that he had fallen. Rose's sister was so concerned for her stepfather's safety (believing Nick could kill him) that she attended a local Police Station. She reported the assault at the front desk, named Nick and described the significant injuries. She informed them that her stepfather did not want to make a complaint. As a result, she was told no action could be taken. No information was taken by the officer, no advice was given, and no reports were recorded on the Police system.

16.4 In January 2021, Essex Police received a non-emergency telephone call from Nick reporting that one of his sisters (not Rose) and brother-in-law were at the address trying to force Shirley to have a COVID vaccination against her will. Nick alleged that during the argument his brother-in-law had verbally threatened him and raised a fist towards him. Officers attended, it was recorded that Nick was very difficult to deal with and changed his account several times making it difficult to understand the allegations. The attending

[24] The author has made every attempt to ensure Rose is central to the chronology however, due to such little interaction with agencies this has proved challenging.
[25] A mental health assessment centre

officers eventually established that there was disagreement as to whether or not Shirley should have the COVID vaccination, which had caused tension within the family and culminated in the confrontation at the house. He stated that a carer for his stepfather had been present but when spoken to, they told officers they did not know what Nick was talking about. A statement was taken, during which Nick told officers he had recorded the incident on his mobile telephone.

16.5 The allegation was recorded, and an investigation commenced. The incident was recognised as domestic related, and a DASH was completed assessing the risk to Nick as standard, and a Safety Plan (DV5) was also completed. Several requests were made regarding the mobile phone recording; however, Nick informed them that the footage did not exist. He provided a statement requesting that no further Police action take place as he did not want to further antagonise the situation within the family.

16.6 In November 2021, Essex Police received a non-emergency telephone call from Nick reporting that earlier in the day his sister (not Rose), had '*stormed into the house*' and had refused to leave. He had tried to leave, and she had placed her hand on his stomach preventing him from doing so. He went on to state that there was an ongoing dispute over Shirley's ill health and potential inheritance. A statement was taken, and the allegation recorded. Rose was recorded as having been at the address but had not witnessed the incident (it is not recorded whether she was spoken to).

16.7 The incident was recognised as domestic related; a DASH was completed assessing the risk as standard and a Safety Plan (DV5) was completed. During a supervisory review, the supervisor recorded that whilst an allegation had been made there was no corroborating evidence of the assault and given the nature of the incident it would not be proportionate to speak to Nick's sister (not Rose). As there was no realistic prospect of a prosecution the supervisor concluded that Nick be informed of no further Police action and further safeguarding advice be given. Although Nick was spoken to, it was not recorded what further safeguarding advice was provided.

16.8 At this stage, Nick was visiting Shirley's home randomly, staying for different periods of time. He moved in permanently once Shirley's husband had passed away.

16.9 Shirley's husband had dementia and due to having care and support needs, he was open to Adult Social Care and in receipt of home care. No concerns were raised by professionals regarding abuse, physical violence, potential conflict, financial hardship or financial abuse during this time. He died in May 2022, aged 100.

16.10 After Shirley's husband's death, she started to get into debt with her energy company and council tax. These bills had previously come out of her and her husband's joint account; however, these funds were reported to have been spent by Nick leaving no money to pay the direct debits.

16.11 At the end of June 2022, a telephone safeguarding referral was made to Adult Social Care by Rose's sister. She was concerned around controlling and coercive behaviour by Rose and Nick, and that they appeared to be taking advantage of Shirley's decline in capacity following their stepfather's death. This concern was raised after Shirley had told her that Rose was bullying and controlling her finances. When Roses sister asked Rose about this (in front of Shirley), Shirley changed her account stating there were no concerns. An initial risk assessment was undertaken with an outcome of '*information and advice given only',*

as Shirley had not consented to a further investigation. Her mental capacity was not in doubt, and she had the legal right to make this decision.

16.12 A month later, Rose's sister made another referral to Adult Social Care due to concerns for Shirley's health and welfare because of Nick's mental health. As part of the initial risk assessment, Shirley was offered a referral to independent advocacy services to support her with a benefits check/application for Attendance Allowance, however, this was declined.

16.13 In November 2022, Rose's sister attended Shirley's home and found her very unwell and requested an ambulance. When leaving for the ambulance Shirley requested her handbag (which had her keys in). Nick was found going through Shirley's handbag which caused an argument. As a result, Nick called the Police stating his sister had walked towards him and he thought she was going to punch him; he also stated this behaviour had been repetitive.

16.14 Given the nature of the allegation and having undertaken a THRIVE risk assessment, it was determined that the incident be dealt with by way of an appointment. Nick repeated his allegation and provided CCTV footage of the incident which was subsequently viewed by the attending officer. Whilst the footage showed a verbal argument, it did not show any aggressive advances.

16.15 Shirley was also spoken with by the officer and whilst she informed the officer that her daughter (not Rose) '*likes to be a nuisance',* she expressed the view that she wished to see her daughter. The officer advised Shirley that her daughter should not attend the house, given the problems this caused. It was recorded as a domestic incident, a DASH was completed where Nick was identified as at standard risk of harm, a Safety Plan (DV5) was completed, and the incident was closed.

16.16 In January 2023, Essex Police received a 999 call from Barclays Bank Fraud Prevention reporting a potential fraud in progress with Shirley. Given the potential risk to a vulnerable person, the incident was graded as a Priority 1 (emergency). Upon arrival, Shirley and Nick were spoken to where it was established that Nick had been speaking to the bank with Shirley in the background. They were making enquiries to commencing the process for Power of Attorney regarding Shirley's finances, the call had become confusing and had caused concern for the bank which in accordance with the Banking Protocol[26], the bank had called the police. No offences were disclosed, and the incident was closed.

16.17 In March 2023, Rose attended the bank with Nick. She withdrew £18,000 from her account (in cash) and left the bank. There is no record what this money was spent on or who it was given to. Additionally, in the last few months of Rose's life, direct debits were set up in her account which were to pay Nick's debts. It is unclear if Rose set these up, if Nick had access to her bank account, or if Rose knew about them.

16.18 Later that year, Shirley received a summons to court from Southend Council for non-payment of council tax.

16.19 In November 2023, Rose was killed.

[26] https://www.actionfraud.police.uk/news/bank-branch-staff-and-police-team-up-to-stop-19-million-of-fraud-in-first-half-of-2020

17. Analysis[27]

The analysis will address the key lines of enquiry within the Terms of Reference.

17.1 This section will explore the following terms of reference together due to their close links:

Consider how (and if there was knowledge of) familial abuse is understood by victims, family, friends, organisations, and the community.

Determine if Rose and/or the family faced any barriers reporting risks and accessing support services, including:

- ***The Equality Act 2010's protected characteristics[28].***
- ***Possible learning difficulties.***
- ***Mental- ill-health.***
- ***Familial abuse.***
- ***Economic Abuse.***

17.1.1 Rose had never reported domestic abuse from Nick to agencies or to her family. This does not mean that abuse was not happening in the household, and as highlighted in the chronology, concerns had been raised by family members to both Police and Social Care. However, this was regarding Shirley and Rose's stepfather rather than Rose.

17.1.2 The family evidently had concerns regarding Nick's behaviour which had been present for many years. They were concerned that he had been violent to Rose's stepfather (who was vulnerable, frail and elderly) and they were worried about his mental health. He also appeared to continue to use his position as the only son who was doted on by Shirley to manipulate the family situation.

17.1.3 When speaking to Nick, it is evident his perception of the circumstances within the household are misplaced, if not fantasy. Nick believes he was the victim of abuse within the household, and that Rose and his other siblings were abusive to him. But upon speaking with Shirley and the family, this is far from the truth. Examples of these false accusations and/or exaggerated memories are:

- *Nick was a child victim of domestic abuse; his father was abusive to Shirley and the children. His father had been in hospital receiving mental health support and electric shock treatment and was a chronic alcoholic. Nick would blame himself and think it was all his fault.* There was no domestic abuse from the sibling's father, and the family recall him as supportive of all the children up until his death and he did not have any addictions to alcohol. Their father did receive treatment for his mental health which included electric shocks after he and Shirley divorced. There was domestic abuse from Shirley's other partners until she met her late husband. This abuse led to her two middle children leaving the home in their late teens. The siblings recall how they felt Shirley would choose the men over her children and that there was neglect within the household. The children do not blame Shirley but believe she would be trapped by the abusive men which impacted her ability to parent, resulting in having an adverse impact on them. Nick was much younger than his siblings, and therefore the impact of these relationships is likely to have impacted him differently. As part of the Domestic Abuse Act 2021, children are now recognised as victims of domestic abuse due to the adverse effects it has on their mental and physical health. It is evident that he also experienced other trauma as a child such as a divorce

[27] The chair and panel are aware that there is very little information regarding Rose, apart from that shared from her family. The analysis will be reviewing family and agency interaction with Rose, Shirley and Nick and have made attempts to ensure Rose has remained central to the discussions.
[28] This has been explored within the Equality and Diversity section of the report.

and his father's poor mental health. These adverse childhood experiences (ACEs) can impact children and young people's development into adulthood. Although they may be more likely to require additional support, these ACEs do not cause someone to be abusive. Domestic Abuse remains about choice, and Nick was in control of every choice he made throughout his time living with Rose and Shirley.

- **Shirley was concerned that the carers coming in for her husband were very rough causing bruising. They would not clean him properly and Rose would have to clean up after they had been.** No concerns had ever been raised about the carers by Shirley or the family, and they were happy with the support going in. Rose did help with the care, but this was when the carers were not present, and when he required help.
- **Nick states he only came back to Essex after Shirley had called him between 30-40 times saying, 'If you don't come back, I can't go on any longer'.** Shirley and the family dispute this and informed the chair they did not have a number for him, and he would either turn up, or they would have to wait for Nick to call.
- **According to Nick, Rose was like Jekyll and Hyde, constantly blaming Nick for everything, would shout, slam doors and demand money from him. As a result, Shirley and Nick would try to avoid conflict as they were both in fear.** Shirley disputed this, stating they had their 'ups and downs' but she had never been frightened of Rose and when they argued Shirley would tell them to stop. Rose managed her schizophrenia well, always attending her reviews with her GP and there were never any concerns regarding her behaviour. In fact, those who loved her and worked with her described as kind and gentle, completely the opposite to Nick's description.
- **He decided to rip out the bathroom and Shirley's bedroom after a flood and the builders had not done a good job.** This is incorrect, the flood occurred after he had ripped out the bathroom leaving no toilet or cleaning facilities. Shirley explained that when Nick wanted to do something he would just do it, and she had no say in the matter.
- **He installed CCTV outside the home and in the lounge, this was apparently to capture abuse from his sisters and neighbours.** Shirley and Rose did not want the CCTV installed and there had never been any trouble with the neighbours. Nick had also taken the wall down so he could watch people parking (on a public road). This was funded through Shirley's finances.
- **He stated living in the home made him exhausted as he did not drive and had to do things for Shirley. He claimed that Shirley smoked 4 packets of cigarettes a week, but after her husband died, she started to smoke 20 – 40 cigarettes a day. He would have to get them for Shirley, and it was expensive, causing financial difficulties.** Again, Shirley and the family stated this was not true, Shirley used to smoke but only a few and has not smoked for years.
- **He claims to have previously had an addiction to alcohol which got worse during COVID, however, he had sought support prior to this from the Mormon church. He has since completed an alcohol awareness course in prison.** The family never remember Nick drinking alcohol and Shirley told the chair that he used to always tell her he did not like alcohol and would never drink it. No concerns were raised with agencies or his GP with regards to alcohol.
- **He claims he has had a girlfriend in Ukraine for 10 years and would like to bring her to this country.** The family (including Shirley) have never heard this before and no evidence of this was found on his devices by the police.

17.1.4 When these comments were discussed with Shirley, she asked why Nick would say these things. It was explained that it is possible Nick would make the comments to try to justify his abusive behaviours and minimise the impact he had on the household. Nick's comments are distressing for the family as they can see he has taken no responsibility for his actions and blames everyone other than himself. Minimisation, denying and blaming others is a common trait that so many abusers demonstrate, as explained within the

Duluth Model[29]. Abusers will create a world that distorts their victims view on the world and on them. They will blame others or use stress and other factors such as alcohol and mental-ill-health to justify their actions. However, these are excuses, and they do not cause a person to be violent or abusive. They may contribute to how the abuser behaves, but at the core of it all the aim of an abuser is to gain power and exert control over another, which Nick appears to have been doing within this home.

17.1.5 From speaking with the family and details provided for the review, financial concern was evident in the last few years once Nick had returned to the home. Economic Abuse is a recognised behaviour within the Domestic Abuse legislation, the 2021 Act widened the context of financial abuse to ensure it captured the range of perpetrator tactics. Surviving Economic Abuse[30] describes:

- ***Financial Abuse*** *- The misuse of money and exerting financial control, for example, controlling someone's bank account or forcing them to take out loans, denying or restricting access to money, or misusing another person's money.*
- ***Economic Abuse*** *- Encompasses many more ways in which an abuser may control someone's economic situation, including through sabotaging their employment or damaging their property, affecting their overall economic stability.*

17.1.6 It is essential that those working with families as well as the community understand that economic abuse is a form of coercive controlling behaviour. Perpetrators target victims' independence restricting their access to vital documentation and services, creating a perception that the abuser is supportive and helpful. It is important to recognise that economic abuse does not always cause dependency. Rather Nick's control of money was through exploitation; for example: taking Shirley's money. This did not cause her to depend on him, rather it created economic instability leading to problems paying the bills, including the council tax. This is relevant as Shirley was summoned to court for non-payment of council tax, potentially making it difficult for her to continue to support Nick and requiring him to get a job and/or support himself. In contrast, Rose contributed to the household.

17.1.7 When we explore Nick's use of financial and economic control over the household, he was not working and not in receipt of any benefits. Yet he claimed that he would have to pay for most things such as the work on the bathroom, which was paid for by Shirley. With no income, he was completely dependent on the money either given by Rose and Shirley. Rose worked incredibly hard, was dedicated to her work and always saved her money. She ensured she paid her 'weekly keep' and voiced her frustration to Shirley that Nick was not paying towards anything within the house. There is no evidence that Rose wanted to stop working but it is possible that with the lack of financial contribution to the household and the increasing debt the family were finding themselves in there was significant pressure on her to continue to work and bring in an income. It is not surprising Rose asked for her money back from him and felt frustrated when he did not pay it back.

17.1.8 Shirley informed the chair that if Nick wanted money, she would give it to him, or he would ask Rose for it. She described how he would travel to London to meet friends (unknown who) and would then return in a taxi, demanding she pay the £80 fare. When asked how this made her feel, she explained she had no choice but to give it to him.

[29] https://www.theduluthmodel.org/wheels/
[30] https://survivingeconomicabuse.org/what-is-economic-abuse/

17.1.9 Nick stated that Rose bought all the food but on one occasion she had not entered the correct pin number on Shirley's card resulting in the card being blocked. However, when speaking with the family, this is incorrect. The card was stopped due to there being insufficient funds in the account to pay for the direct debits/standing orders which was a result of his spending.

17.1.10 Shirley and Rose had never been in debt and had always managed to pay bills including the utility and council tax. Nick informed the chair he had made attempts to make repayments for the council tax and the energy bills; however, he had no income of his own to do this. Shirley was unaware of this debt, and the family also do not believe Rose was aware either as Nick would intercept and shred any letters that came through the post. As a result, the debt continued, culminating in Shirley receiving a court summons for non-payment of council tax from Southend Council.

17.1.11 Southend Council Tax team sent Rose and Shirley a reminder for non-payment in April 2023 with a payment being made seven days later. A 2nd reminder was then sent in May following a default of the May instalment, this, was again responded to with a payment being received. The account was then subject to a final notice in June following a 3rd default, as a result this removed the right to instalments. Although there was no contact with Shirley or Rose, a payment was made five days after the 3rd default (at a reduced sum). A further two payments were then made in July and August (both were late payments). Even though these had been made, the payments prevented the issue of the summons. When this was reviewed in September, due to there being no contact from Shirley or Rose and the continued late payments a summons was issued. Southend Council Tax team informed the panel that they followed their processes correctly, and there was no indication on the account that the resident had any care and support needs. If this had been the case, they have a 'vulnerable' indicator on their system to ensure a more considered approach to recovery action is taken.

17.1.12 Although the council tax team felt they had followed their processes there was no attempt to engage with Shirley or Rose other than send the warning letters. Even if they had not been flagged as 'vulnerable' on the system, concerns should have been noticed by the team that Shirley was an elderly lady with no previous history of non-payment. Proactive attempts to engage and support her make the payments would have meant the summons could have been avoided. Although never diagnosed with a learning difficulty, those who experience these can struggle to open and/or understand letters. If Shirley, Rose, and/or Nick struggled to understand the Council's letters or court orders they may have avoided or not been able to follow the demands set out within these. Although for much of the community it would be the responsibility of the individual to have responded, when a resident is elderly or identified as having care and support needs their welfare should have been explored by the Council. This caring response is going to be even more important in the upcoming years with the cost-of-living crisis and the financial pressures on households. The family wanted to share their disappointment with Southend Council and how they dealt with the outstanding summons after Rose's death, receiving calls only months after (they were informed of the murder) insisting the payments were paid or to expect bailiffs. The family found the experience traumatic and distressing, however, to ensure Shirley was supported they were able to arrange payment of the arrears.

17.1.13 Another concern regarding economic abuse from Nick was when he called Barclays Bank with Shirley, making enquiries to commencing the process for Power of Attorney regarding Shirley's finances. Nick informed the chair this was to get Shirley's card reinstated;

however, this is not true. The family were unaware Nick was making attempts to become Shirley's power of attorney, and it is likely Rose was also unaware of this. It is reassuring Barclays were able to identify to possible concerns around this and call the Police.

17.1.14 Financial abuse is also included in Safeguarding Adults guidance within the Care Act 2014[31]. Even though Police identified there were no offences present, it was an opportunity to have spoken to Shirley and Rose away from Nick. It would have enabled them to try to understand the situation and dynamics at home, consider possible coercive and controlling behaviour and a referral to Adult Social Care. It is possible this was not explored as Shirley appeared to be complicit with the account given to the officers, however, officers need to recognise the complexities with mother/son dynamics especially with regards to domestic abuse.

17.1.15 Although Nick had not obtained Lasting Power of Attorney (LPA)[32] he had made attempts to do so. Dewis Choice[33] and Aberystwyth University produced a guidance document with Cambridgeshire and Peterborough Domestic Abuse Partnership[34] regarding the tactics and risks when an abuser has Lasting Power of Attorney, it states:

- *Ways that LPA can be used to perpetrate domestic abuse - A Property and Finance LPA can be used to make decisions around:*
  - *money, tax and bills*
  - *bank and building society accounts*

  The attorney(s) can start making decisions while the subject still has mental capacity if both the lasting power of attorney (LPA) says this can be done and the subject gives you permission

17.1.16 The abusive behaviour that appears to have been present within this case include:

- ***Control access to benefits, pensions and any other money the victim has – withholding the victim's bank card, using it without their knowledge to withdraw money, using their money to fund drug or alcohol addiction (the victim may feel guilty about refusing money for substance abuse for fear that the abuser will become unwell without it).*** As already noted, Nick was spending Shirley's money, creating debt and non-payment of bills, he was also insisting she paid for the work on the house and taxi fares. Shirley stated she did not feel she could say no to him as he was her son, and she would have done anything for him. Although she may not have been fearful, the thought that she would not be providing for him and the possible pressure he placed on her meant she was unable to refuse his demands.
- ***Medical care or withholding care.*** Nick had argued with his sister that Shirley should not have the COVID-19 vaccination. He informed the chair this was Shirley's decision, and he was supporting her with this, but it is unclear what was the truth during that time.

17.1.17 Where concerns are raised regarding a person who has care and support needs and there is a Lasting Power of Attorney a referral to Adult Social Care should be made, a DASH should be completed, and specialist support should be offered.

17.2 This section will explore the following terms of reference together due to their close links:

Review agencies response, professional curiosity, interventions, care, treatment and or support provided to Rose, Nick and/or the wider family.

[31] https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets
[32] A Lasting Power of Attorney is when someone appoints another person(s) (attorney) to make decisions on their behalf.
[33] https://dewischoice.org.uk/information-and-advice/resources/
[34] https://www.cambsdasv.org.uk/web/older_people/567583

Analyse whether the 'Whole System' and 'Think Family' approach was considered and applied especially with regards to familial abuse, conflicting issues within families with adult family children and carer needs.

Consider whether the work undertaken by services was consistent with each organisation and local professional standards, domestic abuse and safeguarding policies, procedures and protocols and ensure adherence to national good practice.

Examine services and agencies response to the welfare of any adults at risk of harm especially with regards to familial abuse.

Review the communication between agencies, services, friends, family, and the community including the transfer of relevant information.

17.2.1 Between 2007 and 2023 there were five relevant contacts with Essex Police due to issues between Nick and his sister (not Rose) and/or his brother-in-law. At no time during the police investigations into these matters were significant concerns raised or identified in relation to vulnerability, mental- ill- health, familial or financial abuse.

17.2.2 When Nick attended the Police station in 2007 and spoke with a member of staff wishing to report threats made towards him by family members, and produced a handwritten note (which had obvious signs of alteration), the member of staff concluded that no offences had taken place and determined that the incident related to potential mental-ill-health. Nick was advised to speak with his doctor/GP and an incident was created recording the interaction with Nick and the advice given. This was in line with practice at the time.

17.2.3 Since 2007, Essex Police has made significant changes to the way in which it deals with incidents involving mental-ill-health. In 2014, Essex Police introduced the Mental Health Street Triage Team to provide practical help, support and advice to staff dealing with anyone who is displaying mental -ill- health.

17.2.4 They have also developed training in recognising and dealing with persons displaying signs of mental-ill-health, which is now embedded into a variety of training courses provided to staff and officers, resulting in an increase in staff awareness.

17.2.5 In 2023, a new process was introduced for highlighting and sharing concerns with partner agencies in relation to individuals displaying signs of mental-ill-health where there are indicators of serious violence, homicide, high risk of suicide or are a high service user, but who do not meet the Section 136[35] Mental Health Act 1983 criteria, in the form of a mental health referral process via an on-line form MHT1.

17.2.6 As such, had Nick presented at a police station today, as he did in 2007, staff would have the option to seek advice from the Mental Health Street Triage to enquire whether Nick was open to Mental Health Services to ensure that all risk factors are considered to enable an appropriate response.

[35] https://www.legislation.gov.uk/ukpga/1983/20/section/136

17.2.7 With the recent establishment of the Mental Health Team and the Mental Health Risk Management Board there is now an improved process to identify individuals posing a significant risk due to mental- ill -health and mechanism by which a partnership response to such individuals can be developed to manage the risk.

17.2.8 Rose's sister was proactive in trying to seek help for those living within the household. When she approached the Police, she raised:

- Allegation of physical assault,
- Elderly gentleman (95 years old),
- Vulnerabilities including dementia, care needs, him being bed bound,
- Abuser was a family member
- There were other people with care and support needs within the home.

17.2.9 However, due to her stating her stepfather did not want to make allegations she was turned away, with no action or record taken. Nick was still present in the home and there was an elderly man who required care and support with potential injuries who remained at risk of harm. An incident should have been created and a welfare check requested to see if there were any safeguarding concerns within the household. Why this was not done, we do not know, however, the impact on the family has been long lasting.

17.2.10 The family believed the Police should have protected their stepfather and acted on their concerns, especially as there had been such significant injuries. They voiced they felt let down, as they could not protect their stepfather especially as he was bed bound and had no means to either protect or seek help himself. This impact meant they did not reach out to Police again and may never seek support from them in the future.

17.2.11 When the DASHs were completed with Nick in January 2021 and November 2021, he disclosed that he had depression (it is not recorded if this was diagnosed depression, or he was feeling depressed). There are no records of these disclosures being explored any further by the attending officers or what advice was given to Nick in response (i.e., seeking support from his GP or contacting partners within Mental Health). This may have been due to the disclosures not being of the nature that prompted the officers to consider immediate safeguarding or to seek the advice of the Mental Health Street Triage Team and were not indicative of there being any immediate risk to himself or others. That said, it may have been beneficial to have signposted him to support in the future.

17.2.12 During that same period, the catalyst for the domestic related incidents arose from concerns in relation to the care of Shirley and access to the property for the family to see her. With the two incidents in 2021, although Shirley was recorded as having care and support going into the home and being present, she was never spoken to. Additionally, the sibling's stepfather was living at the address but there are no records that the Police knew an elderly male who required care and support was present in the home (who had Adult Social Care support). Without these discussions, they were unable to fully explore support options with either person.

17.2.13 Rose was recorded as being present in the STORM incident log of the domestic incident at the beginning of November 2021, but there is no evidence that Rose was ever spoken to. The incident recorded that there were no witnesses to the incident, however, it is unclear how this was determined. The evidential statement taken from Nick, whilst detailing the events and naming his sister (not Rose) as the aggressor, made no mention of Rose, Shirley or his stepfather.

17.2.14 The incident in November 2022, recorded that Shirley had been spoken to but no details of what she said were recorded on the Athena investigation. With all these investigations, Shirley was not recorded as an involved party within Athena despite her being central in the dispute between Nick and the wider family. This meant her wishes and feelings were never taken into consideration, and she had no voice during the Police involvement.

17.2.15 All recorded consideration of risk and vulnerability centred on Nick as the nominated victim of the investigations. Whilst this is in keeping with procedure, officers and staff must also be cognisant of the wider impact of domestic abuse upon the family. Taking a 'Whole family' approach and where vulnerabilities are identified (either children or vulnerable adults) the necessary referrals to partners should be made. In this case there was an absence of professional curiosity in relation to the potential vulnerability of those living within the household, resulting in a missed opportunity to assess whether there was a need to share information with partners such as Adult Social Care.

17.2.16 When Nick made the allegations of threats or assault, the Police determined that no further action would be taken. On the first occasion in 2021, Nick stated he did not want his sister and/or brother-in-law to be spoken to as it may antagonise the situation. His wishes were met, and no action was taken. However, he did not make these requests during the two other occasions, therefore this would have been an opportunity to have spoken to his sister. This may have enabled the officer to understand the concerns present within the family, enhancing their understanding of risk and any safeguarding concerns.

17.2.17 The family also feel they were let down when they raised their concerns of possible abuse to Adult Social Care and believe more intervention could have been offered to everyone living within the household, including Nick.

17.2.18 After Rose's stepfather died in May 2022, Nick moved permanently into the home. Rose's sister had significant concerns for Shirley and raised these to Adult Social Care alleging controlling and coercive behaviour by Rose and Nick in relation to Shirley's finances. Although Adult Social Care reported their response was appropriately and proportionately responded to as per SET safeguarding policy and guidance, there were several opportunities missed to have further explored the dynamics within the home.

17.2.19 Shirely was seen by the social worker at her home address; Nick was present as was his sister who had raised the concerns. Rose was not present as she was at work. The Adult Social Care report states that Shirley was able to speak freely, give her views, make decisions and was provided with information and support. The social worker told the IMR author that they were not expecting Nick to be present as Shirley's daughter had arranged the meeting. When discussing this with the family, they informed the chair that Nick never left the house, and he had initially told them he was going to refuse the social worker access to the house. As a compromise, the sister felt, even if he were present Shirley would still be seen. The main concern the social worker recalls was that Rose was not paying anything towards the household bills, however, Shirley told them this had been resolved, and she was clear that she did not want to take this matter any further. The family believe Shirley was trying to obtain more money from Rose to fund Nick. Rose's sister deeply regrets making these allegations against Rose, however, at the time felt she needed to act to protect her mother, she also recalls briefly speaking with the social

worker when they were leaving who raised their concerns regarding Nick's mental health but explained there was nothing they could do.

17.2.20 It was not appropriate to speak to Shirley in the presence of Nick as he had also been accused of abusing her. She should have been seen on her own, or with her other daughter so they could both share any concerns. Having Nick present would have undoubtedly created an uneven power dynamic within the meeting. The social worker never asked to speak to Rose, and her not being present meant she did not have an opportunity to have her voice heard, yet Nick's was. The social worker has reflected on this and recognises they should have taken time to organise another visit to speak to Shirley on her own to confirm beyond any doubt that she did not want or need any support with her finances or to take matters further. This omission should have also been picked up at the authorisation to close stage as it would have prompted the social worker. Unfortunately, this did not happen, it is unclear why and the supervisor no longer works for the Council.

17.2.21 The consequence of Nick being part of these discussions and Shirley's devotion to him, is likely to have meant that she would never have felt able to have raised any concerns in front of him. Therefore, the assessment was flawed from the outset.

17.2.22 Coercive control is still not fully understood or identified by those who work with individuals who have care and support needs. It would have been expected that the social worker would have considered this with the allegations made and carried out appropriate risk assessments (such as the DASH) with Shirley. Too many times, victims of coercive and controlling behaviour are hidden in plain sight, especially when there is no physical abuse. It is essential therefore that social workers can recognise the signs and complete these risk assessments to enhance their knowledge of the situation at home. As Nick was present this would not have been appropriate, however, they could have gathered enough information to complete the form and evaluate the risk.

17.2.23 At times, the DASH can feel clumsy for those who are older or subjected to abuse from a family member, therefore the Cambridgeshire and Peterborough 'Older Persons DASH'[36] devised by Dewis Choice and Aberystwyth University may be of some assistance. This document was devised for those over 60 years old and/or those subjected to familial abuse ensuring the questions are more appropriate for victims. Although many of the questions are the same as the SafeLives DASH, questions which may have given Shirley the opportunity to have highlighted the situation at home are:

- *Q21. Is the person that is abusing you also providing care for you (formal or informal) or are you caring for them?*
- *Q22. Is the person that is abusing you an immediate family member? (please indicate) Partner (or ex) / Son / Daughter / Son-in-Law / Daughter-in-law / Grandchild (state if abuser u18)*
- *Q23. Are there any financial issues? For example, are you dependent on (.....) for money or are they dependent on you for money?*
- *Q25. Has (....) taken money from you without your consent, or pressured you into giving them money?*
- *Professional Judgement: Other relevant information (from victim or professional) which may alter risk levels: Consider the victim's situation in relation to disability or health issues, substance misuse, and mental health concerns?*

[36] https://www.cambsdasv.org.uk/web/older_people/567583

- *Consider if the victim is reliant on the abuser for care of any sort (including help with managing the household, collecting shopping or medication as well as personal care), consider the impact of losing this support on the victim*
- *What are the victim's greatest priorities to addressing their safety?*

17.2.24 These questions may have enabled the social worker to have explored what was happening within the household, discussed Rose's sister's' concerns, identify any abusive behaviours, evaluate the risk and seek appropriate support. There was no evidence that the social worker advised Shirley or her daughter to go to the Police if there were concerns regarding coercive or controlling behaviour, or signposting to specialist support regarding domestic abuse. Even if it had been declined, the information would have been available for the family to have considered.

17.2.25 Only a month later, Rose's sister made a further referral to Adult Social Care due to concerns for Shirley's health and welfare because of concerns regarding Nick's mental-ill -health and both his and Rose's learning disabilities. Adult Social Care had no records to indicate that Rose or Nick had learning difficulties or had any care and support needs themselves. They were however, concerned for Shirley and an assessment was arranged over the phone.

17.2.26 As part of the initial risk assessment, Shirley was offered a referral to independent advocacy services to support her with a benefits check/application for Attendance Allowance which was declined. The social worker followed this up but again it was declined. This response was appropriate with the information known; however, it may have been beneficial to have cross referenced the concerns raised the month prior and considered speaking with the family's GP.

17.2.27 Although Adult Social Care practitioners receive E-Learning regarding domestic abuse, it is unclear in how much depth the social worker completing the assessment considered domestic abuse and whether they felt confident asking about the dynamics in the household. Rose's sister had told social care that Shirley was very protective over Rose and Nick, and therefore this may have been a barrier for Shirley to have shared the true extent of the situation. As already noted, it is unclear whether Rose or Shirley realised what they were experiencing was familial abuse. Therefore, practitioners should be given the skills to feel confident and competent in not only asking questions but also be able to recognise other 'social cues' present.

17.2.28 Every contact Adult Social Care had with the family (including those when Rose's stepfather was alive), did not adopt a 'Whole Family' approach to identify wider needs. This would have been particularly useful especially when exploring the concerns regarding the alleged financial and coercive control. Additionally, it would have ensured all members of the family were included in any support offered and/or planned.

17.2.29 Most importantly, if this had been explored further, both Rose and Nick would have been spoken to find out any pressures they were under, and what (if any) support was required. Rose would have had an opportunity to have a voice; she would have been able to speak to someone about what was happening and the impact it was having on her. Instead, she was an invisible resident within the house, working hard, supporting the household and alone. Nick remained at the forefront of any contact with any agency, with him calling the Police and being present during the social care visits.

17.2.30 He shared with the chair that his mental health was poor, however, this was never explored with him by the social worker. Again, if time had been taken to have explored the stress and pressure, appropriate intervention and support may have been offered to him. Although Social Care were involved when Rose's stepfather was alive, no Carer's Assessment was ever offered to Rose or Shirley. After he died and Rose and Nick became Shirley's carers, there was an opportunity for the social worker to have suggested a Carer's Assessment to see what help (if any) could have been offered.

17.2.31 After these meetings and involvement with the Police, Rose's sisters informed the chair that the wider family met to discuss how they could support Shirley due to feeling let down by agencies. As a result, they made the decision to manage the situation privately and would not contact agencies again. The impact of this response remains with them to this day.

17.3 Consider if the COVID pandemic impacted the health and wellbeing of Rose, Nick and/or the family as well as services provision and response.

17.3.1 There was evidently friction within the family when they disagreed about the COVID-19 vaccination. However, upon speaking with the family they do not believe the pandemic impacted on Rose, Shirley and Nick's health and/or wellbeing.

17.3.2 When reviewing agency responses, Police attended on each occasion, with Adult Social Care providing multiple in person and telephone contacts along with Occupational Therapists and Physiotherapist services (because of Rose's stepfather's care and support needs). Throughout the period, no concerns were raised by professionals regarding potential conflict, financial hardship or financial abuse by family.

17.4 Conclusion of analysis

17.4.1 In concluding this analysis, it is important to distinguish clearly between what is evidenced within agency records and family accounts, and what represents professional interpretation informed by research and practice knowledge. The documented evidence shows that Rose had long-standing caring responsibilities within the family home, that Nick had a history of unstable employment and difficulties maintaining relationships and boundaries, and that no agency identified domestic abuse or raised safeguarding concerns prior to the homicide. Records confirm that Rose's mental health was stable and well-managed, and that neither sibling had a formal diagnosis of a learning disability despite attending schools for additional learning needs. The circumstances of the homicide itself are also evidentially clear: an argument escalated, Nick assaulted Rose, and then fatally stabbed her.

17.4.2 Professional interpretation, grounded in this evidence and supported by established research on domestic abuse and adult family violence, suggests that the dynamics within the household were consistent with a pattern of intra-familial abuse that is often hidden and under-recognised by services. The accounts provided by family members indicate longstanding patterns of entitlement, manipulation, and gendered expectations in Nick's behaviour, which align with known risk factors for harm in adult family abuse. Although agencies did not have clear indicators of imminent risk, the combination of entrenched family dynamics, unresolved trauma, dependency, and gendered power imbalance created conditions in which Rose was vulnerable to serious harm. This interpretation does not extend beyond the available evidence but seeks to contextualise it within the

wider research base on domestic abuse, older victims, and adult family violence. Taken together, the analysis demonstrates that while agency involvement did not reveal obvious safeguarding triggers, the underlying pattern of behaviour within the family home was consistent with a form of domestic abuse that is frequently overlooked, and which ultimately placed Rose at significant risk.

18 Learning and recommendations

18.1 Rose was invisible to all the agencies who interacted with this family. Although she was noted within records, she was never spoken to, and her voice was never incorporated within any assessment or care plan. Rose was an independent woman who was working hard to maintain a home for her and Shirley. Nick appears to have been taking advantage of Shirley, using his status as the only son and manipulating Shirley and Rose financially. As with most abusers, his voice was louder than Rose's or Shirley's and he appears to have had control of the situation within the home. Family members were evidently concerned for Shirley and Nick's mental wellbeing; however, coercive control and the impact of his manipulation was never considered within any assessment. These were missed opportunities to have fully explored what was happening within this home.

18.2 In September 2023, Essex Police introduced the AWARE principles with the primary focus to improve professional curiosity in relation to the Voice of the Child (VOTC). This was in response to several statutory reviews in which it had been identified Essex Police investigations were consistently failing to identify vulnerable children during domestic abuse investigations and take steps to safeguard them. Any interaction with a child during an investigation, particularly investigations of domestic abuse in which there are children within the home setting, should be recorded on Athena utilising the Protecting Vulnerable People Tab – VOTC. An entry should also be placed on the investigation log utilising the AWARE mnemonic to ensure there is a structured process to help officers assess any potential vulnerability and act accordingly. To underline the importance of AWARE, the Principles have been embedded into the Essex Police Parent Policy and Child Abuse Investigations.

18.3 The current Flex Training of AWARE is being delivered to front line staff within the Local Policing Teams focusing on children rather than adults who have or may have care and support needs. Additionally, AWARE does not feature in any other Essex Police Policy and Procedure relating to children or 'vulnerable' adults including, Essex Police Policy – Protecting Vulnerable People & Domestic Abuse.

18.4 The utilisation of the AWARE Principles is an effective framework to ensure officers and staff apply professional curiosity and in doing so identify potential vulnerability. Whilst the focus of Essex Police has been to ensure officers and staff apply the Principles to ensure that the Voice of The Child is heard (improving safeguarding and the exchange of information with partners), the principles are equally relevant to the improvement of the delivery of safeguarding and exchange of information with partners in relation to adults who have or may have care and support needs.

18.5 The importance of applying the AWARE Principles to adults with care and support needs has been recognised by Essex Police and as such the training has been revised with greater emphasis on utilising AWARE for both children and adults. This training was implemented in Summer 2024 and takes the form of mandated training for all relevant front-line staff. If applied correctly it is envisaged that the use of AWARE will improve

professional curiosity and in doing so improve upon the recognition of vulnerability, ensuring that safeguarding and support are in place where appropriate.

Recommendation 1
The Crime & Public Protection Command Senior Leadership Team should ensure that the AWARE Principles are embedded in the relevant Essex Police Force Policies & Procedures (i.e. Protecting Vulnerable People Procedure, Safeguarding Vulnerable Adults Policy, Domestic Abuse Policy and Domestic Abuse Investigations Procedure).

18.6 Implementation of this recommendation should be evidenced through the completion of the policy review already recorded on the Force Action Tracker, with clear documentation showing that all relevant Essex Police policies and procedures now reference and require the use of the AWARE Principles. Outcome measures should include confirmation that the eight policies previously lacking AWARE content have been updated, alongside audit activity demonstrating that officers are applying AWARE within Protecting Vulnerable People, Safeguarding Adults and Domestic Abuse investigations. Monitoring should be overseen by the Crime & Public Protection Command Senior Leadership Team, with progress reported through the existing Force Action Tracker and to SETDAB at agreed intervals. This will ensure that the policy changes translate into measurable and sustained improvements in professional curiosity and the identification of vulnerability.

18.7 We will never know if Rose was frightened of Nick as she was never asked and never sought help and support. It is essential therefore to raise awareness of familial abuse within the community and the behaviours that may be present, in order to increase the public ability to recognise and report the abuse. Any campaigns need to ensure the subtle tactics used by abusers are included ensuring the language used is relatable to the target audience.

18.8 Southend-on-Sea Domestic Abuse Strategy 2023-26[37] identified that domestic abuse in the area was under reported, with residents describing multiple barriers. Their survey indicated that 34% of residents had never disclosed to any professional about their experiences. Additionally, the Strategy notes that only 60% of professionals had received domestic abuse training, with only 33% feeling equipped to identify abuse. An objective set out within the Strategy is to promote societal change and raise awareness.

18.9 As such, a campaign raising awareness of domestic abuse affecting older people was launched in 2024 by the SETDAB Domestic Abuse Partnership called, 'It's Never Too Late'[38]. The campaign aims to empower older people to recognise abuse and seek help. The campaign uses content and visuals adapted from the 'Hidden Harms' animation, co-created by domestic abuse survivors aged between 60 and 93-years-old from Dewis Choice. It explores different types of abuse such as emotional, physical, sexual and economic abuse, along with coercive control and encourages victims to seek help. Whilst this provides excellent awareness of familial abuse and domestic abuse to older people, a gap has been identified that domestic abuse between siblings is missing from the content and campaign.

18.10 When raising awareness, it is essential that systems are in place to deal with concerns raised by family/friends/and community and that they are taken seriously, with different

[37] https://democracy.southend.gov.uk/documents/s63147/Domestic%20Abuse%20Strategy%202023-2026.pdf
[38] https://setdab.org/resource/setdab-its-never-too-late-campaign-2024/

abusive behaviours being fully explored. This will enable the whole picture to be understood and ensure that relevant and appropriate support and intervention is offered. To achieve this the whole family (not just those living in the home) should be spoken to and given a voice, are heard and involved in any care plan and decision making, ensuring the safety of everyone involved.

Recommendation 2
Southend-on-Sea Council and SETDAB to ensure any public awareness campaigns incorporate siblings within familial abuse, highlighting the complexities and possible tactics used by abusers.

18.11 Implementation should be demonstrated through the inclusion of sibling-to-sibling abuse within the SETDAB Strategic Communications Plan and its integration into future public awareness campaigns. Outcome measures may include updated campaign assets, evidence that this audience segment is represented in campaign planning, and evaluation data showing increased public understanding of familial abuse beyond intimate partner relationships. Monitoring should be undertaken jointly by SETDAB and Southend-on-Sea City Council through their established communications governance processes, with progress reviewed against the May 2025 target date. This will help ensure that the learning leads to sustained improvements in public awareness and earlier recognition of familial abuse.

18.12 Raising awareness also needs to take place within the agencies who interact with families where familial abuse may be present (For example, where caring responsibilities are present). Adult Social Care, need to have domestic abuse at the forefront of their minds when there are concerns for a person's wellbeing. They should not be reliant on a disclosure being made but be proactive in seeking information and using their professional curiosity to understand the dynamics of the relationships. Without this, adults who have care and support needs will continue to be hidden in plain sight.

Recommendation 3
Adult Social Care are to reinforce practice when working with families experiencing domestic abuse ensuring all significant family members are proactively involved where appropriate.

18.13 Implementation of this recommendation should be evidenced through delivery of the Principal Social Worker practice note, completion of the planned workshop session, and the Adult Social Care Quality Assurance deep dive on family involvement. Outcome measures should include audit findings demonstrating improved documentation of family engagement, increased referrals to MARAC where appropriate, and practitioner feedback confirming strengthened understanding of domestic abuse within family systems. Monitoring should be undertaken through Adult Social Care's existing quality assurance framework, with progress reported to the Southend Community Safety Partnership in line with the May and September 2025 milestones. This will ensure that the learning is embedded into practice and results in sustained improvements in whole-family safeguarding.

18.14 The Citizen Advice Bureau report that council tax debt is the most common debt they encounter and that this has risen in the last three years. In 2022, it was recorded there were approximately 547,000 residents living with a Southend-on-Sea postcode. Therefore, it is essential the council can provide support to those who are struggling to

pay their debt. Citizens Advice Council Tax Protocol was developed in partnership with the Local Government Association; the protocol offers practical steps aimed at preventing people from getting into debt and outlines how to ensure enforcement agents act within the law. The Protocol asks that councils:

- work with enforcement and advice agencies to help people pay their council tax bills while accessing debt advice;
- ensure all communication with residents about Council Tax is clear;
- use the Standard Financial Statement when calculating repayment plans;
- offer flexible payment arrangements to residents;
- do not use enforcement agents where a resident receives Council Tax Support;
- publish their policy on residents in vulnerable circumstances

18.15 Shirley (and we believe Rose) were unaware of the non-payment of council tax as Nick was any mail coming into the home and then shredding it. Although the council are confident, they followed their process, they did not take into consideration that Shirley may be vulnerable due to her age and that she had never missed a payment previously. If time had been taken to contact Shirley (and/or Rose) other than via letter, their circumstances could be explored, and they could have been helped with regards to repayment and benefits.

18.16 Southend-on-Sea Council are currently working towards becoming an accredited member of the Domestic Abuse Housing Alliance[39]. This will ensure there is a continued commitment to support victims of domestic abuse and will enhance support offered to any victim who approaches the council. However, to further improve the response domestic abuse (including economic abuse) training should be introduced to the council tax team.

Recommendation 4
Southend-on-Sea Council to ensure their safeguarding and domestic abuse policy and training includes economic abuse and all Council Tax staff attend.

18.17 Implementation of this recommendation should be evidenced through delivery of the bespoke safeguarding and domestic abuse training to Council Tax staff, with explicit inclusion of economic abuse and the learning from this review. Outcome measures should include training attendance records, pre- and post-training confidence assessments, and audit findings demonstrating improved recognition of economic abuse and appropriate safeguarding referrals within Council Tax processes. Monitoring should be undertaken through Southend-on-Sea Council's existing safeguarding and workforce development governance structures, with progress reported to the Southend Community Safety Partnership against the June 2025 target date. Evidence of strengthened operational links between Council Tax and Adult Social Care teams should also be captured to demonstrate that learning has translated into sustained improvements in practice and earlier identification of residents who may be vulnerable or at risk of domestic abuse.

18.18 The family feel the risk Nick poses to Shirley, them and the wider family was not fully recognised by the judge and or agencies who interacted with the family. They requested for the recommendation regarding this report to be included within the risk assessment

[39] https://www.dahalliance.org.uk/

at the parole board (which if he is eligible) will be in 2036. However, due to the significant amount of time that will have passed they understood this was not a practical recommendation to oversee by the CSP or SETDAB. However, a request has been made to Nick's Custody Probation Officer that the review will be included in any risk assessment prior to any parole board.

19 Conclusion

19.1 This review has highlighted that Rose's homicide occurred within a context of long-standing family dynamics that were not recognised by agencies as domestic abuse. The evidence shows that although Rose, Nick and Shirley had contact with services, no organisation identified patterns of adult family violence, nor were safeguarding concerns escalated. Professional interpretation of the available information indicates that entrenched behaviours, gendered expectations, and unresolved trauma within the family contributed to an environment in which risk was present but remained invisible to practitioners. This aligns with national research demonstrating that adult family abuse, particularly against older women, is frequently under-identified and poorly understood.

19.2 The learning from this review therefore centres on the need for improved recognition of familial abuse, stronger professional curiosity, and clearer pathways for responding to concerns that fall outside traditional intimate-partner models of domestic abuse. The recommendations reflect these findings by emphasising the importance of: strengthening practitioners' understanding of adult family violence; ensuring that safeguarding responses consider the whole family system; improving information-sharing and multi-agency coordination; and supporting staff to identify risk where caring roles, dependency, or cognitive vulnerabilities may mask abuse. By embedding these lessons, agencies can enhance their ability to identify and respond to similar patterns of harm in the future, reducing the likelihood of such tragedies recurring.

19.3 The family, conclude that Rose had the right to live a happy, peaceful life and Nick had no right to take that away from her. The family spoke of the horror when they found out what Nick had done to Rose, but they explained they were not surprised. Both sisters have voiced that they are terrified for theirs, Shirley's and their family's safety if/ when Nick is released from custody. They believe that if Shirley is still alive when he is released, he will manipulate her to live back in the home and he has the potential to kill her or one of them. Both said '*if he could kill Rose then he can kill one of us*'. It is vital therefore that the whole family are protected from him.

Final word from the family

Poem - Afterglow.

I'd like the memory of me to be a happy one.
I'd like to leave an afterglow of smiles when life is done.
I'd like to leave an echo whispering softly down the ways,
Of happy times and laughing times and bright and sunny days.
I'd like the tears of those who grieve to dry before the sun;
Of happy memories that I leave when life is done