Herefordshire
Community Safety Partnership

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

into the circumstances

of the death of a woman aged 70 years

on 11th August 2014

Case HDRH 02

Under Section 9 of the Domestic Violence Crime and Victims Act (2004)

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LIST OF ABBREVIATIONS

CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment Tool)
DHR	Domestic Homicide Review
DMHOP	Department of Mental Health for Older People
GP	General Practitioner
HCSP	Hereford Community Safety Partnership
HM Coroner	Her Majesty's Coroner
IMR	Individual Management Review
MAPPA	Multi-Agency Public Protection Arrangement
MARAC	Multi-Agency Risk Assessment Conference
MDTM	Multi Discipline Team Meeting
NHS	National Health Service
PCMHT	Primary Care Mental Health Trust
SIO	Senior Investigating Officer (Police)

Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 70 year old woman on 11th August 2014. The woman's husband, the Perpetrator also died in the same incident. This tragic case was reported to HM Coroner for Herefordshire. On 8th April 2015 Assistant Coroner Mr Roland Wooderson recorded that the Victim had been unlawfully killed by the Perpetrator who then took his own life.

Details of the legislation governing the Domestic Homicide Review process, the terms of reference, panel members and agencies that contributed to the review are contained in an appendix to this report.

For the purpose of this executive Summary of the Domestic Homicide Overview Report, the Victim, Perpetrator family members and other that were involved with the review process will be anonymised. A key is provided for ease of reading.

Victim	Female, aged 70, wife of Perpetrator
Perpetrator	Male, aged 71, husband of Victim
S1	Female, daughter of Victim
S2	Male, son of Perpetrator and former partner
GD	Granddaughter of Victim and Perpetrator - Daughter of S1,
FF	Family friend of Victim and Perpetrator
H	S1's husband
DW	Divorced wife of Perpetrator

Summary of events.

The Victim and Perpetrator in this case had been married for 38 years. Both of them were in their 70's and lived a comfortable lifestyle in a Herefordshire village. The Perpetrator had been a professional man supported in his business by the Victim. Both were especially well regarded by other residents in the village and the Victim led quite a busy social life within the village.

The Perpetrator was and had been for many years, a registered shot gun licence holder. West Mercia Police will say that there was never any cause for concern about his licence which was regularly inspected by the local Police Firearms Officers.

Three years after moving into the village, the Victim was diagnosed with Alzheimer's. She had a long history of medical problems especially chronic obstructive pulmonary disease which increasingly incapacitated her

The Perpetrator was recovering from Prostate problems, but generally in good health.

The couple were described as a devoted, loving couple. Each of them had a child from previous marriages, the Victim had a girl, (S1) now a professional woman with a family of her own, and the Perpetrator had a son, (2) again with a family of his own. The son did not have much contact with his father (the Perpetrator) following family problems. The daughter has a teenage granddaughter on whom both the Victim and the Perpetrator doted.

In 2014, a neighbour of the couple sought planning permission to establish a caravan park for members of the travelling fraternity in a field at the bottom of the couple's land. This caused concerns with the residents of the village and the Perpetrator led a campaign group in objection to the application.

At the beginning of January 2011, the Victim's health began to deteriorate. She had emphysema that had caused significant and permanent damage to her lungs resulting from her previously poorly controlled asthma, and during that year she was a regular attendee at her GP's surgery. She was referred to Improving Access to Psychological Therapies [2]gether Let's Talk Services and it was suggested that she join the expert patient's programme to support her to manage her long term medical conditions.

By July 2012, the Perpetrator attended at the GP's surgery expressing concerns about his wife's memory which was deteriorating. He reported that she was often concerned about what other people may be thinking about her especially at social events. S1 would later describe how her mother had to withdraw from a one-time busy social life as her dementia worsened.

During the latter part of 2012, the Victim continued to deteriorate and require increasing medication for her conditions. In October 2012, the Victim was seen for an initial assessment by the Primary Care Mental Health Team (PCMHT) following a referral from the GP. She was found to be low in mood, distressed but with no self-harm ideations. She took a memory test that indicated her memory had deteriorated over the last two years and she had now a considerable loss of memory.

By January 2013, the Victim's memory had deteriorated again. She was struggling to orientate herself in place and time. She was questioning repeatedly, having difficulty in recalling faces and getting lost in unfamiliar places.

In February 2013, the Perpetrator was offered a carer's assessment and a referral was made for Carer's Assessment. He was registered with Herefordshire's Carers Support group.

By June 2013, the Victim had a respiratory tract infection and by August 2013, she was unwell again, worrying and not sleeping. She described herself as being lonely. It is recorded that the Perpetrator was also unwell. During August 2013, the GP spoke to the couple and suggested that they register with the local Alzheimer's Support Group as by now the Victim had been diagnosed with Alzheimer's.

On 25th June 2013, the Victim was seen for her 6 month follow up appointment with the Memory Clinic. This had been brought forward as a result of concerns from the Perpetrator. The Perpetrator was offered a Social Services Carer's Assessment and referred to a Carers Assessor and registered with Carers Assessment. There is no record of any formal carer's assessment being completed. There is no record of the assessment in the notes of [2]gether which was determined to be unsatisfactory during the Trust's internal review.

In October 2013, there is an entry in the [2]gether IMR to the effect that attempts were made to contact the Perpetrator by telephone after he had written asking for advice. It is not documented if that contact was made or followed up. A note in the IMR identified that despite asking for help and assistance, the Perpetrator often declined the offers of help.

Also in October 2013, the Perpetrator attended at his GP's surgery complaining of headaches and anxiety.

In December 2013, the Victim was referred to the Admiral Nurse Service.

On the 6th December 2013, the Admiral Nurse wrote to the GP stating that the Perpetrator had been seen by the admiral nursing service and that he was struggling to adjust to his wife's

changing needs and was seeking further information about Dementia and how to manage his wife. Later that month the Victim attended the Memory Clinic where she was found to be disorientated, more forgetful, low in mood and feeling isolated within their village. She was not going out. The following day the Perpetrator telephoned the GP's surgery stating that the Victim was low, tearful and becoming aggressive, being the result of the side effects of the medication. The GP IMR author helpfully comments at this stage that the Victim's respiratory function was worsening. She was having repeated and poorly responsive chest infections.

By February 2014, the Victim's breathing difficulties were by this time affecting her 7 days per week, resulting in her struggling to have a shower or get dressed in the morning and she had had to give up her walking club as she could not keep up with her peers. Her daily living activities were being restricted and company with friends was limited.

In April 2014, the Victim had several emergency admissions to hospital. During one of the admissions, she had to wait three hours before she was seen and the Perpetrator later wrote a letter of complaint to the hospital.

In May 2014, the Admiral Nurse Service continued to have significant contact with the Victim and the Perpetrator. The Victim was referred to the Well Check service of Age UK. The couple had assistance with benefit claims and the Blue Badge Service. The Perpetrator was able to contact the Admiral Nursing Service as often as he wished. He was also able to contact his wife's Consultant Psychiatrist. It was May 2014, that the Perpetrator admitted to the Admiral Nursing Service that he was unable to cope with his wife.

The Perpetrator was a very strong willed person, who was completely devoted to his wife. He was not however able to come to terms with the fact that is wife's condition was not going to improve. He looked for the one diagnosis and one medical intervention that were going to cure her. He was unable to accept the inevitable, that his wife was not going to recover. He was also of the view that no one could look after his wife better than he could and his apparent reluctance to accept support was based on tradition values that he was responsible for looking after his wife.

In June 2014, the subject of Palliative Care for the Victim was discussed within medical circles but it was appreciated that this would upset the Perpetrator so the subject was not broached with him. Instead he and his daughter considered that a temporary respite care at a Care Home would give the Victim the care she needed and also give the Perpetrator the beak from the routine daily task of caring for his wife's every demand.

In the meantime the Victim's health continued to deteriorate. She was agitated, confused, disorientated, verbally aggressive and showing challenging behaviour and she was unpleasant to live with.

In July 2014, a Community Psychiatric Nurse saw the couple at their home. The Victim reported that her husband would grab her arms and the Perpetrator said that his wife was getting him mixed up with her former husband with whom there had been domestic violence. The CPN reported that there was no evidence of abuse or bruising on the Victim.

During early part of August 2014, the Perpetrator and his daughter were looking for a Care Home for respite care for the Victim and they chose a specialist dementia care home in Worcester. On Wednesday 6th August 2014, the Perpetrator and his daughter persuaded the Victim to go to the care home. There had been a pre- admission assessment conducted at the family home by a member of staff from the care home. The result of that assessment was that the Victim required mild dementia care, but the assessor recalls how the Perpetrator was keen to explain how he had cared for his wife and that his wife's condition was not that serious. This

was a common theme with the Perpetrator, who often minimised the seriousness of his wife's condition when talking to professionals.

However on admission it was clear to the care home manager that the Victim's needs were more than initially assessed and arrangements were made for her to be placed in a more suitable room.

The Perpetrator was reported to be present at the home most of each day and during the evening he would contact and home to ensure that his wife was being cared for adequately.

On Friday 8th August 2014, the Perpetrator called early in the morning to be told that the Victim had been restless during the night. He attended immediately and discovered that his wife had not been given her nebuliser since being admitted. He wished to make a complaint and as the manager was speaking to him in his wife's room, another resident who seemed confused entered the Victim's room and struck out at the manager. The manager removed this resident back to her own room and during this time, the Perpetrator removed the Victim from the care home and returned her to their own address. He sent a letter of complaint to the manager with payment for the three days his wife had stayed there.

On Saturday 9th August 2014, the Perpetrator asked his daughter to contact a friend who was supposed to be going to his house the following day for Sunday lunch and to cancel her. The daughter could not make contact with her but left the friend a text message.

It appears that the friend did not receive the text message, because she attended at the house on Sunday lunch time and got no reply. She left. The daughter tried to contact her parents during Sunday but again got no reply.

On the morning of Monday11th August 2014, still not getting any reply the daughter contacted the police and made her way to her parent's house. The police made a search and found the bodies of both the Victim and the Perpetrator in a locked shed. Both had died from gun-shot wounds. The Perpetrator's shot gun was by his side.

A Police investigation commenced and it was soon evident that no one else was involved in the shooting. There were no signs to indicate that the Victim had been taken to the shed against her will.

HM Coroner found that the Victim had been unlawfully killed by the Perpetrator, who had then turned the gun on himself.

The views of the family

Home Officer Guidance requires that the family are involved in the DHR process. The daughter of this couple has been seen on two occasions by the DHR Author and information has been shared with her and her family as the review has progressed.

On the first occasion, the daughter and her family gave the author a detail description of what kind of people her mother and father were and how her father was desperate to look after his wife rather than anyone else. She described how he had old fashioned values about caring for his family. She and her family were very appreciative of the review process and any comments they had have been faithfully recorded within the overview report.

The second meeting was for the author to explain the findings of the review and the recommendations. The daughter was very supportive of the finding and the recommendations made within the IMR action plans.

The daughter is a senior manager with a support agency for older people, so she is well aware of the issues surrounding the care for the elderly especially with dementia cases.

She does however strongly disagree with the comments made by the manager of the care home and the improvements that the manager has or intends to implement. The daughter's view of the manager's comments is that all the manager intends to do following a similar incident should have already been in place. The care home was chosen as it was reputed to be a specialist dementia care home and she found it was not equipped to cater for her mother's dementia. The daughter's views have been included in the Overview Report.

The daughter however, stated that she cannot praise enough the medical care that her mother and father received especially from the Admiral Nurse Service. She also praised the Police in the manner in which they dealt with the initial scene and the ongoing investigation which they did in a sensitive and compassionate manner.

Finally she commended HM Coroner in the manner in which he conducted the inquest also in a sensitive manner.

Conclusions

The circumstances surrounding the deaths of these two loving and devoted pensioners are desperately sad. It is clear from the information contained in the respective IMRs that the Perpetrator was unable to face the future without his wife. He was also unable to face her deterioration that he was witnessing as his wife's condition became worse. He tried everything to care for his wife and there is a great deal of evidence suggesting that he did not accept that she was not going to get better.

There is however a consideration that the Perpetrator contacted so many agencies and health departments seeking advice and information, (often only the information and advice that he wanted to hear and of course he did not hear that), often more than one in the same day. There is nothing to suggest that all of these departments and agencies were identified and 'pulled together' to share information in a coordinated manner.

It may have been that a coordinated approach to their problems, a more structure support plan could have been implemented. Such a plan may not have prevented the death of the couple but it may have made understanding the future for the Victim a little clearer. As it was, the Perpetrator was dealt with individually by agencies, departments and various professionals.

The Perpetrator was a registered firearms certificate holder and owned a shot gun, as do up to 20,000 in the West Mercia Police area. Whilst the applicant for a firearm certificate is asked to indicate on the form the identity of the GP, there is no mandate for GPs to be informed by the police that a patient is the holder of such a licence. Equally, if the GP knows that a patient has a licence there is no mandate to inform the police should that patient become ill with an illness that may affect his ability to possess a firearm.

The Overview Report suggests that this is something that ought to be brought to the attention of ACPO (Association of Chief Police Officers) who are at present conducting research and study into such issues and also considering the outcome and recommendation of a DHR in Durham which concerns similar issues. There is also work being conducted by the Law Commission regarding similar issues. West Mercia Police have included the fact that liaison will be made with the ACPO working group within their IMR recommendations.

The Perpetrator was referred for a carer's assessment but there is nothing to indicate that such an assessment was carried out. In the ^{2}gether IMR recommendations are made with

regarding this issue that include training and awareness. Another area covered in the [2]gether IMR recommendations is a review of care plans which was absent in this case and the lack of a co-ordinated plan to look at both the mental and physical health of both the Victim and the Perpetrator. These issues are adequately contained in the [2]gether IMR and action plan.

The Community Safety Partnership has also made improvements to systems with regard to the delivery plan for the DVA Delivery Group. This now includes developing and delivering as part of the multiagency DVA training, a new unit covering age, dementia and other vulnerabilities as a possible indicator of DVA. Similarly, the DVA referral pathways and advice for professionals are being revised to reflect DVA and older people, and DVA and vulnerability.

During the course of this review, two experienced panel members visited the care home in question and were struck with the care home and its policies and procedures for caring for patients with dementia. The manager explained improvement that she had made at the home since this incident, which included dementia training for all staff, a Mental Capacity Act assessment process to understand the prospective resident's understanding of the move to a care facility and the development of a system to include identification of family carer's needs as we'll as the resident's needs.

What followed in the next 24 hours or so after the Perpetrator removed the Victim from the care home, no one will know, but one can imagine the desperation of the situation that the couple must have found themselves in. Neither of them could imagine being without the other and the Victim's health was deteriorating rapidly. She had indicated that she wanted to die so the Perpetrator took the steps to end the life of his wife and then end his own. No one will know if this was planned or a spontaneous action, or in fact, whether the Victim appreciated or agreed with what was to happen.

The fact remains that the Perpetrator, in a desperate act, took both of their lives. His actions could not have been predicted or prevented and despite attempts of the media to link this with the planning application in the adjacent field, there is nothing to suggest that this effected the Perpetrator's decision.

Recommendations

Individual Management Report Recommendations

West Mercia Police Recommendations

1. West Mercia and Warwickshire Police Firearms Licencing Departments to consider the feasibility of implementing the wording of the Recommendation 6 of Durham DHR re Adults A-F (February 2013) and report back to the Hereford Community Safety Partnership within 3 months. (see below for 3 parts of that recommendation):

a) The Police firearms licensing departments explore the feasibility of carrying out checks both internally and externally with other agencies in particular primary health care i.e. GP's, to help them make decisions in relation to the granting of either a shotgun or firearm's licences. In order to help them to do this and risk assess appropriately, consideration should be given to establishing a system so that consent is sought for the disclosure of information from every person in that household from primary care services. This will enable information to be shared relevant to domestic abuse, substance miss-use, physical harm and mental health issues.

b) Once a firearm or shotgun certificate has been awarded, the police firearms licencing department should notify the individual's GP so that they are proactive in their information sharing if they have concerns about the certificate holder and their appropriateness to continue to hold these certificates.

c) During the course of those discussions the police representative should also seek permission for a 'flag' to be placed upon the individuals medical record which identifies that if granted a licence it is clearly visible to those accessing the record.

Wye Valley NHS Trust Recommendations.

1. Trust to look at ways of ensuring that information leaflets for carers of patients with a diagnosis of dementia is given to all carers, in order that they are aware of hot to access help if required.

2. Trust to liaise with partner agencies to consider developing a carer's self-assessment tool to be completed by carers of patients with dementia, in order to identify those carers who may be having difficulties coping.

2gether NHS Foundation Trust

1. Deliver a learning event to the teams involved in this episode of care delivery. This will provide staff with the learning from this review and give education on the actions.
2. Provide a Trust wide briefing on this case, detailing the observations, learning and recommendations from this individual management report. This will be communicated and Team managers will be directed to discuss in Team meetings.
3. SBARD training will be delivered to the teams involved in this case and will also be made available to other Trust services in Herefordshire.

4. Conduct an audit of carers assessments completion and review dates will be completed for the Herefordshire Memory Assessment Service and Older Person Services.

5. Conduct an audit of completion of care plans, risk assessments and crisis contingency plans for the Herefordshire Memory Assessment Service and Older

Person Services.

6. Development work on better liaison and promotion of careers support services linked with wider Trust work in this area. This will include the development and communication of strategies to be used when reasonable support is being refused.

7. Review the interface between the Memory Services, Primary Mental Health Teams and Older Adults Community Mental Health Teams utilising the learning from this review.

8. Review the Herefordshire Memory Assessment and Older Person Services sharing of information with clinicians, patients and carers, including the practice of copying or addressing letters to patients. This will also consider the sharing of information regarding medication and care planning.

9. Provide clear guidance to ensure that patients and carers are offered and consistently reminded of a clear single point of contact at whatever level they are engaged, and that appropriate supporting information is given regarding planned interventions and indications for contacting services before crisis.

10. Provide clear guidance on the process for ascertaining that a carers assessment has been requested, and undertaken or refused, should be reviewed, including its documentation and reference to actions in RIO.

11. Provide additional training and guidance for the Herefordshire Memory Assessment Service and Older Persons Services regarding safeguarding information on older persons abuse issues.

12. Meet with Wye Valley Trust nursing lead to discuss methods for improving communication between services in light of the learning from this IMR.

Hereford Clinical Commissioning Group Primary Care

1. Map of Medicine needs to include the car pathway for domestic abuse

2. The care pathway needs to be reviewed to assess whether it is fit for purpose for all age groups, amended as necessary and published on adult focused web
3. The CCG to include a link to the document ‘Managing Pain in Dementia’ in their next GP newsletter

Admiral Nursing Service

1. All cross boundary Admiral Nursing cases to be discussed at Clinical supervision to ensure that there is a plan to try and gain access to information.

2. When Care Notes Electronic records are introduced, separate records should be created for carers who are in receipt if direct interventions from Trust services with links to the patient’s records so that other services within the Trust can have access to carer records. Separate interventions for a carer would be visible and in the case

of Admiral Nurses, the involvement of the service would be clear to all who view the record.(the Admiral Nurse would still need to maintain their WANDA records)

3. Where Admiral Nursing Service are seeing carers, key points of information and concern should be actively shared with other members of the care team e.g. GP and Psychiatrist etc via telephone, email or letter as appropriate

Appendix No 1

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

into the circumstances

of the death of a woman aged 70 years

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Case HDRH 02

The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011. Under this section, a domestic homicide review means 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 he was related or with whom he was or had been in an intimate personal relationship, or*
> *(b) a member of the same house hold as himself, held with a view to identifying the lessons to be learnt from the death"*

In March 2013, the Government introduced a new definition of domestic violence and abuse[2], that states that domestic violence and abuse is:

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:*
> - *psychological*
> - *physical*
> - *sexual*
> - *financial*
> - *emotional*

In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. The members of the panel consisted of senior professionals from:

- Learning and Development Officer, HSCB/HSAB/HCSP
- Principal Social Worker, Adult Social Care Herefordshire Council
- Head of Safeguarding – CCG Quality
- Lead Nurse Adult Safeguarding, Wye Valley NHS Trust
- Deputy Director of Nursing – 2gether, NHS Foundation Trust
- Assistant Chief Officer, National Probation Service
- Chief Executive, West Mercia Women's Aid
- West Mercia Police
- Safeguarding Lead, Adults Wellbeing, Herefordshire Council

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

- Observing members from West Mercia Women's Aid and Hereford CCG.

The CSP appointed an independent author and chair to be responsible for writing the report and chairing the panel meetings.

None of the panel members or the independent author had direct involvement in the case, nor had any line management responsibility for any of those involved.

It was decided that the review should focus on the period from 1st January 2011 (the year the Victim was first diagnosed with Alzheimer's disease) to the date of the Victim's death on 11th August 2014.

The following agencies were requested to prepare chronologies of their involvement with the Victim and her family, and to prepare individual management reviews and produce reports:

- West Mercia Police
- Health – Including 2gether and Wye Valley NHS Trust and Herefordshire CCG
- Barchester Latimer Care Home, Worcester
- West Mercia Women's Aid
- Adult Social Care
- Additional Representation from Carers Support and Age Concern

Terms of Reference

The Terms of Reference for this DHR are divided into two categories i.e.:

- the generic questions that must be clearly addressed in all IMRs; and
- specific questions which need only be answered by the agency to which they are directed.

The generic questions are as follows:

1. Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?
4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?
5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
7. What were the key points or opportunities for assessment and decision making in this case?
8. Do assessments and decisions appear to have been reached in an informed and professional way?
9. Did actions or risk management plans fit with the assessment and the decisions made?

10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and in what way, were the victim's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the victim should have been known?
13. Was the victim informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the perpetrator? For example, were they being managed under MAPPA?
16. Had the victim disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?
23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
24. How accessible were the services for the victim and the perpetrator?
25. To what degree could the homicide have been accurately predicted and prevented?

In addition to the above, some agencies will asked to respond specifically to individual questions once they are identified following the submission of IMR's.