

Executive Summary

Central Beds CSP



SaferCentral

Community Safety Partnership

A Domestic Homicide Review (DHR) concerning the death of Bridget (pseudonym) (November 2023)

Author – Jackie Dadd

Date completed – June 2025

The Domestic Homicide Review Panel and the members of the Central Beds Community Safety Partnership would like to offer their sincere condolences to the family of Bridget, who have lost their loved one in tragic circumstances.

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1. The review process

1.1 This review examines agencies responses, provisions and support provided or available in the Central Bedfordshire area to Bridget, a 74-year-old female, prior to her death, having been murdered in her own home by her 'lodger', Cody in November 2023. Her death was established by Bedfordshire Police in April 2024. Cody admitted murdering and dismembering Bridget and was sentenced to life imprisonment at Luton Crown Court. Cody had debts of about £30,000 and had stolen Bridget's jewellery both before and after she had died for over £5,000.

1.2 Bedfordshire Police made a referral to Central Beds Community Safety Partnership (CSP) in June 2024 for consideration for a Domestic Homicide Review (DHR) and following a meeting held later that month with representatives from local Authorities, a decision was made to undertake a Domestic Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met as Cody was living at the same address as Bridget.

1.3 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following: (All ages are recorded at the time of Bridget's death).

Bridget – Deceased. A white British female who was 74 years old.

Cody – Perpetrator. A white British male who was 45 years old.

Brian – Bridget's estranged husband.

Olivia – Brian's partner.

Richard – Brian's son who saw Bridget as his mother.

1.4 Central Beds CSP wrote to Brian informing him of the DHR and providing details of AAFDA if he wished for support. The Author then contacted Brian by telephone and arranged a Teams meeting in which she spoke to both Brian and Olivia separately at length, offering them the opportunity to meet the panel and re-iterating the benefits of AAFDA support but they chose to decline and were content for the Author to keep them updated. The communication methods were Brian's choice and he was content for the author to choose the pseudonyms in the report which he agreed with.

1.5 Brian was sent a copy of the overview report prior to submission to the CSP in which he was pleased with its accuracy and conclusions.

1.6 The Author made contact with Cody via letter to His Majesty's Prison (HMP) who responded to state that he was willing to speak with the Author. A lengthy interview was held with him in which he outlined the fact that he could not cope with the pressure of being Bridget's carer and did not ask for assistance, even though he had worked in this capacity previously and was fully aware of the processes.

2. Review panel members

2.1 The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of IMRs, Summary reports and chronologies.

2.2 The panel comprised of the following:

Name	Area of responsibility	Organisation
Lisa Scott	Safer Communities & Partnership Manager	Central Bedfordshire Council
Nina Page	Team Manager	Central Beds Domestic Abuse Service
Toni Doherty	Head of Safeguarding	Bedfordshire Hospitals NHS Foundation Trust
Jeanette Keyte	Head of Community Safety, Parking and Programmes	Central Bedfordshire Council
Leire Agirre	Head of Safeguarding and Quality Improvement	Adult Social Care – Central Bedfordshire Council
Richard Tilling	DCI – Safeguarding Reviews	Bedfordshire Police
Dr Jamil Akhtar	Doctor	GP Surgery
Katherine Carragher	Practice Manager	GP Surgery
Joy Leighton	Senior Operations Manager	Victim Support/IDVA Bedfordshire
Joanna Wilson	Designated Nurse Safeguarding Children and Children in Care	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Amanda Derbyshire	Designated Professional for Safeguarding Adults	Bedfordshire, Luton and Milton Keynes Integrated Care Board

2.3 Thanks go to all who have assisted and contributed to this review with their valued time and cooperation.

3. Contributors to the review

3.1 The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of scoping their records and if necessary, providing reports and chronologies.

Agency	Contribution
Central Beds Community Safety Partnership	Oversight, Panel member
Bedfordshire Police	IMR, Panel member
Bedfordshire Victim Support	Panel member
Bedfordshire Adult Social Care	IMR, Panel member

Bedfordshire Hospitals NHS Foundation Trust	Panel member, Scoping
GP Surgery	Summary report, Panel member
Bedfordshire, Luton and Milton Keynes Integrated Care Board	Panel member, Summary report
Hertfordshire Hospitals NHS Foundation Trust	Summary report
Central Beds Domestic Abuse Service	Panel member
East London Foundation Trust	Scoping
Victim Support Homicide Service	Scoping

3.2 The following agencies were contacted for scoping but provided a nil return and had not had contact with any subject in this review:

Bedfordshire Probation Service
Bedfordshire MARAC
Bedfordshire Fire and Rescue Service
Bedfordshire Victim Support
East London Foundation Trust re: Bridget
Department of Work and Pensions

4. Author of the Overview report and Chair

4.1 The chair of the review panel and Author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues, having been the Force Lead for domestic abuse, stalking and harassment and serious sexual offences and has been involved in the DHR process since its inception in 2011.

4.2 She has completed several training courses including the Home Office online training, the Continuous Professional Development accredited AAFDA (Advocacy After Fatal Domestic Abuse) DHR Chair training, the domestic Abuse and suicide accredited course, and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has obtained the accredited qualification of a level three certificate in Chairing a Domestic Homicide Review.

4.3 Mrs Dadd has completed and published several DHRs.

5. Terms of Reference

The Terms of Reference were discussed and agreed upon during the first panel meeting and was a working document throughout the review.

It was agreed that the main areas of focus and discussion would be based on the following:

- a) To establish if Domestic Abuse (DA) in any form had been the causation or contributory factor in the death of Bridget.
- b) What were the responses to calls for concern and were they effective?
- c) Are policies and procedures effective in safeguarding those vulnerable to domestic abuse?
- d) Establish if economic abuse is identified by professionals and the safeguarding measures surrounding this area.

The full Terms of Reference are below:

- The parameters for this review will be taken from the beginning of 2022 until the conclusion of the trial of Bridget's perpetrator, Cody.
- This is to be reviewed as a Homicide based on the investigation by appropriate authorities and the findings of the Crown Court.
- Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process.
- Are support services and provisions within the Central Beds area for identifying and supporting those suffering from domestic abuse accessible to elder persons?
- What procedures are in place to appropriately risk assess a vulnerable person when concerns are made by a third party.
- Was there collaborative working when concerns were raised about Bridget and how effective was this?
- Are policies and procedures appropriate for an accurate risk assessment when a person is reported as a missing person. Are they applied appropriately and resourced sufficiently?
- Is there an adequate understanding of economic/financial abuse and the response that may be required. Are there limitations that create barriers?
- Was there sufficient professional curiosity as to how needs are met by informal care arrangements?
- What is the impact of the de-registration from a GP Practice to those who are vulnerable and in need of support and what support is provided to re-register.

- Do professionals recognise DA when the relationship does not present as intimate but is still covered by statute.
- To include any learning to the unpaid carers strategy refresh that is currently ongoing and ensure domestic abuse is included within the strategy.
- Consider if unconscious bias was present due to the reporting person being the new partner of Bridget's estranged husband.
- Did agency intervention identify or consider Bridget's protected characteristics. Were any of the other protected characteristics relevant in this case?
- Identify good practice.

6. Summary chronology

6.1 Bridget had married Brian and became a mother to his son in 1992. When they separated in 2003, they remained married due to financial reasons and Brian continued to support her with £3000 to pay her bills and payment of her credit card when she moved to Bedfordshire in 2008. Brian would begin a relationship with Olivia in 2016.

6.2 Around 2013, Bridget met Cody by chance as he worked in the social centre near to where she lived. His relationship had recently broken up and he had no place to live so Bridget offered him a room at her house. The reason why is not clear, but it is known that Cody did not once pay rent or lodgings in the ten years he lived there.

6.3 The above arrangements continued throughout the years. In April 2020, during the Covid 19 outbreak, Bridget attended the emergency department at Lister hospital for weakness on her right side and falls. She was diagnosed with suffering a stroke and received treatment whilst being an inpatient for two days. She listed Cody as her Next of Kin and records state that there were no concerns raised and that she left the hospital with sufficient mobility with the aid of a walking stick.

6.4 In June 2022, Bridget attended the Accident and Emergency Department at hospital with a laceration to her forehead following a fall, which required 4 x sutures. A week later, she attended her GP Surgery where a practice nurse removed the sutures. Bridget reported to the hospital that she was coming back from the toilet when she felt dizzy (she had complained of dizzy spells intermittently since her stroke) and fell, hitting her head on the floor. She reported no loss of consciousness and was able to call her carers who came and helped her.

This was the last occasion that anyone from the GP Surgery saw Bridget.

6.5 In November 2022, Olivia contacted both the police and Adult Social Care (ASC) on behalf of Brian expressing concern over Bridget potentially being the victim of financial abuse due to the fact that she was incurring debts for the first time and bills were not being paid, yet she was still receiving her payments. ASC recorded this as a safeguarding contact and rang Bridget who informed them that she was fine and no unmet care needs and did not require an assessment. Olivia had contacted ASC on two occasions as she was concerned

that they were not acting on her information. ASC provided her with information for a cleaner at her request through Age UK and it was finalised as no further action as no abuse was identified.

6.6 Following the phone call from Olivia, the Police completed a welfare check on Bridget at her home as Brian had not been able to get half of her for two and a half weeks. It transpired that Cody was away at the time. Officers spoke to her at her front door in which she informed them that she was fine and the incident was closed as they had no concerns and she had been seen safe and well at home. No referrals were made and there was no communication between ASC and the police although they knew of each other's involvement.

6.7 Due to an expanding area, in July 2023, Bridget's GP Surgery sent her a text message and a letter informing her that she would be de-registered from the practice in 30 days' time and deducted from the patient's list. Bridget did not register with another surgery and it is not known if she received this message. Between the 4th of May 2022 and the 5th of September 2023, the GP Surgery had messaged Bridget on 22 separate occasions in which she had not replied, having done so previously.

6.8 Bridget last saw friends and neighbours in November 2023 and were then told by Cody that Bridget had gone to stay with a friend. A neighbour who had always had a key, found that she couldn't gain access to the house. He then went on to tell the family the same thing, stating that she had gone off in a car from outside the house.

6.9 Family received presents via email from Bridget at Christmas and the messages accompanying them were not in the manner that Bridget would have written them. On the 10th of January 2024, Olivia once again contacted the police on Brian's behalf telling them that Bridget has an unofficial carer who last saw her in November and that nobody has heard from her since.

6.10 Olivia outlined background information around Bridget of concern and the measures that Brian and herself had taken to locate her to no avail and despite there being a number of concerns highlighted, she was informed that Bridget did not reach the missing persons criteria. Brian and Olivia were not satisfied with the police response, so Brian hired a private investigator to try and find her. Cody moved out of the property in early April and Brian gained access to Bridget's house to find that all of Bridget's belongings were still there and her phone and passport were under the bed.

6.11 Olivia contacted the police once more in April 2024 outlining her concerns again and the fact that it had now been six months since she was last seen. Bridget was declared a missing person and a few days later, following a review of the police lines of enquiry, the police declared that it was a murder investigation. Cody was arrested several days later on suspicion of murder.

6.12 He was interviewed in custody and immediately admitted being responsible for Bridget's death stating he had killed her on 8th November 2023 by suffocating her with a pillow whilst she slept in her bed. He kept Bridget's body within the house for a number of

weeks before dismembering her and disposing of her body. Parts of her body were discovered in a storage unit described by Cody in a town near to her home. He was subsequently charged with the murder of Bridget.

6.13 Parts of Bridget's body remain unrecovered due to being disposed of in various bins. Cody has since admitted a few days after he killed Bridget, an estate agent came round the house to take measurements for the impending sale and Bridget was in a cupboard under the stairs.

7. Key issues arising from the review

GP Surgery's protocols with elderly, vulnerable patients

7.1 The ICB have confirmed that the GP Practice followed national guidance and procedure when de-registering Bridget from their practice along with 149 other patients due to her living out of area and the demand they faced. This was done by text message and letter, giving her 30 days to register at a new surgery. The panel appreciated the fact that it would be unmanageable to assist all 150 people but if Bridget's circumstances were viewed holistically, she has suffered a stroke within the past four years, they are unaware if she receives communication from them via phone as she has not responded to 22 texts over two years, her age and the length of time she has been at the practice, then would the consideration of ensuring they have had contact with her to clarify that she was aware and also ascertain if she need assistance with finding another GP.

7.2 The majority of the texts from the GP Surgery were not responded to as aforementioned, were in relation to requesting blood pressure results to assist with the repeat prescriptions that Bridget had for medication. These were always applied for online by Cody which was unknown to the GP Surgery yet no efforts to see or speak to Bridget were made even though the repeat prescriptions continued.

(Recommendations refer)

Criteria for recording a person as missing

7.3 Bedfordshire's missing person policy clearly sets out procedures and considerations for staff receiving reports of missing persons. It defines a missing person as 'Anyone whose whereabouts cannot be established will be considered as missing until located, and their well-being or otherwise confirmed.'

7.4 A person will not therefore be recorded as missing on Compact (missing person computer system) until the carer/reporting person has undertaken reasonable actions to ascertain the whereabouts of the absent person, unless there is a real immediate risk of harm that justifies immediate police intervention. Olivia had outlined all the steps they had taken to locate or speak with Bridget.

7.5 This criteria fit Bridget when Olivia contacted the police in January 2024 yet was not declared a missing person by the call handler following her speaking to her supervisor. It is accepted that this would have brought a different outcome but timeliness may be an issue for other persons who meet the criteria.

8. Conclusions

8.1 Cody lived rent free in Bridget's home for over ten years. Bridget's health and mobility only began to deteriorate once she had a stroke in 2020 and Cody became her unofficial carer. It was at this stage that she became more dependent on Cody as the years went by.

8.2 Apart from seeing her neighbour who had a key to her home, she began to see less and less people, staying in her room for long periods and due to her mobility, did not go out as she couldn't drive her vehicle, providing Cody with control over her finances as he was in possession of her credit card to do her shopping.

8.3 Concerns were raised in 2022 by Bridget's estranged husband Brian and his partner, Olivia to both the police and Social Services when they noticed the amount of debt owed by Bridget through their joint account, despite Brian sending sufficient funds each month to cover her bills. Neither service considered making any enquiries into Bridget's finances and did not appear to consider economic abuse. The police attended the address for a welfare check and was told by Bridget that she was fine and Adult Social Care made a phone call to Bridget in which she re-iterated that she was fine and although a question was asked into financial abuse, it was a passing question and welfare was more a concern.

8.4 There was no wider consideration by ASC of the needs of Bridget when she stated that her carer was away. Olivia observed that there was unconscious bias from ASC as she introduced herself as the partner of Bridget's estranged husband and that the concerns that she made in relation to financial abuse were misconstrued due to this which may be a reason it was not looked at in detail. The language in the IMR for ASC would also suggest this.

8.5 In July 2023, Bridget's GP practice informed her she would be de-registered from the practice as she lived out of area. The panel have identified that due to a number of factors taken together, although the GP Practice followed protocol, direct contact should have been made with Bridget to ensure she received the message and to her capabilities of finding a new surgery.

8.6 In January 2024, when Olivia again rang the police with concerns over Bridget, stating that she had not been seen by family or neighbours since November, she was not identified by the call operator or her supervisor as a missing person. The Police acknowledged, having conducted an internal de-brief which is good practice, that the information provided by Olivia did meet the criteria of a missing person and Bridget should have been deemed so and enquiries immediately undertaken.

8.7 The observations and comments from Brian in relation to the Victim Support Homicide Service (VSHS) were outlined to them following discussion at the panel meeting and although they conversed with the Author at length via email and phone, they declined to join the panel or provide the information sort, even when consent had been provided by Brian. They have reviewed their case notes and reflect that they do not entirely match the information provided by Brian who self-selected to withdraw from their service citing no further need as he felt that providing no support or information of value, if anything, was more likely to increase stress without contributing anything positive.

8.8 VSHS are content that part of their process is a follow up phone call and this was adhered to and they acknowledged that although they do not normally assign a caseworker with the same name as the deceased, this was an oversight on this occasion.

8.9 Due to the assurance of the processes already being in place, the panel did not feel that there was a requirement in respect of recommendations. The panel did express disappointment that the national service 'could not see the causal link between the support provided to a family member post homicide and the prevention of that homicide and therefore did not feel their actions were pertinent to the DHR as the panel feels that the effect of domestic abuse spreads wider than that of the victim and the correct service should be available to families following the death of a loved one.

8.10 The lack of a centralised carer register for unpaid carers is an area that the panel feels is required to provide oversight on those who are caring and those who are being cared for due to the heightened risk of domestic abuse occurring in these circumstances. If Cody had been spoken to and admitted that he had left the 'caring' profession due to stress as he couldn't cope, then this may have been assessed as to his capabilities. As a 'hidden adult', Bridget's mobility and depression deteriorated and with no oversight, left Cody in total control of her consequences and able to abuse and exploit her vulnerability. Conversations took place in relation to adults affording the same response as that of a child in similar circumstances.

8.11 Economic Abuse is identified by the credit card being used to the amount of £8000, the removal of items belonging to Bridget for Gold for cash in which Cody received over £5000, the accrual of debt in Bridget's name and the use of her car for his own means. Physical abuse is identified in the malnutrition of Bridget and the murdering of her. It cannot be ascertained as to whether the dirtiness of Bridget's house, which included soiled incontinence pads lying around could have caused her emotional or psychological harm and led to increased depression or the reason that she would no longer come out of her room as stated by Cody.

8.12 Without the majority of her remains, due to Cody disposing of them, it cannot be ascertained if there was any evidence of further abuse to Bridget as Cody showed a disrespect of her body in its dismemberment and disposal of body parts and then for six months, continued what the Judge described as an elaborate lie to cover it up.

9. Lessons to be learnt

9.1 Insufficient professional curiosity to ascertain a person's wellbeing and safety.

Bridget was living in an unclean home that was untidy with soiled incontinence pads lying around. She was malnourished, suffering from depression according to her family and was not being cared for properly.

Opportunities to identify this by professionals were available but not taken. The Police went to Bridget's home and spoke to her on the doorstep as a welfare check yet didn't enter her home or engage in sufficient conversation to ascertain her personal capabilities and would have been faced with the state that her family had found if they had done so.

Adult Social Care made a phone call to Bridget and having asked some questions, were satisfied that there was no cause for concern or care needs based on what Bridget had told them. The lack of a visit to Bridget's home by Adult Social Care was a missed opportunity to identify neglect as outlined by Brian who had gained entry to the house and saw that it was in an unfit state.

On both of the above occasions, it cannot be certain that Cody was not at the location and Bridget was answering in fear.

Bridget did not respond to 22 text messages from the GP Surgery, having done so previously and was not seen at the surgery for over a year whilst being prescribed medication until she was de-registered without any personal contact to ascertain her circumstances and ability to find another Practice.

Professionals must take that extra step and ask additional questions rather than be satisfied with the initial response, in order to have a more informed understanding of their needs and circumstances.

9.2 Lack of recording of the details of a carer, whether paid or unpaid

It is acknowledged that the risk of domestic abuse is heightened when a person requires a carer who is unpaid and living in the same household either to the carer or the person being cared for. All carers are entitled to a carers assessment under the Care Act 2014 but data from Carers UK shows only around 25% of carers have a carers assessment.

There were multiple occasions from several organisations where the details of Cody could have been taken and recorded. Although ASC offered an assessment to Bridget in 2022 over the phone and it was declined, there was no consideration in offering Cody an assessment, even when Bridget was discharged from hospital following a stroke. Therefore, he was a 'hidden' carer and Bridget was a 'hidden' adult exposed to abuse due to her disabilities from the stroke, reliance on Cody, immobility and age which all together, made her vulnerable.

Had Cody been spoken to by professionals in relation to his capabilities of being a carer, then he may have disclosed the fact that he had to give up his previous profession of being a carer

as he couldn't cope and it caused too much stress. This may have led to professionals providing closer scrutiny on his capabilities as a carer.

10. Recommendations

National

- 1. A centralised register is required for all unpaid/unofficial carers to be recorded when they come to the notice of professionals, with a record of who is receiving care and who is providing that care in order to prevent 'hidden adults'.**

This will ensure that once a person cared for becomes known to a professional, a record will be made on who is their carer which will allow for both care and risk assessments, when necessary, due to the known correlation between domestic abuse and carers heightened risk.

- 2. Domestic Abuse Commissioner's office to incorporate within the already undertaken oversight mechanism research into DHRs/DARDRs, the element and impact of a carer as a specific area of focus.**

The panel felt that this was an important area of focus and particularly relevant to Central Bedfordshire as they have had four recent reviews where a carer has been involved.

Local

- 3. ICB to review local process for list cleansing and develop guidance to support practices for implementation.**

This to ensure that the message is received and also that they have the capability to identify and register at another practice as failure to do so could be to the detriment of their health.

- 4. Bedfordshire Police to update the Standard Operating Procedure Policy to ensure that Command and Control STORM incident logs are endorsed with comments by a supervisor supporting the rationale for a report not to be recorded as a missing person. This is to include an additional review following any subsequent information that may be placed on the log once it has been closed.**

This is to provide oversight on rationale and ensure that missing persons are not overlooked by those who may not be as experienced in identifying the triggering factors from the information provided. It will also ensure that any further information is reviewed and taken into account and not just placed on a closed file where it will not come to anyone's attention.

- 5. Bedfordshire Police to implement that where there is any suspicion of criminal involvement in a missing person enquiry, a PIP 3 SIO is to be assigned and the investigation team should consist of PIP 2 trained officers and staff with the support of the CMIT officers.**

This will ensure the experience in investigation is met as it is a different skill set to that of finding missing persons. This will ensure that the enquiries are focussed on a criminal act and information is gained evidentially.

- 6. GP practice to review the process for ongoing prescribing when patients do not attend for medication reviews or related assessments. This is to support safe prescribing and monitoring of a patient's wellbeing.**

This is to ensure that personal contact with patients is maintained and any additional needs or reasons for not responding to technical communication can be explored to assist in identifying any safeguarding requirements.

- 7. Bedfordshire Adult Social Care to provide training to the Safeguarding teams on conversations and recording around care needs in sufficient detail to make an informed decision.**

This will provide understanding on the importance of asking the right questions and showing professional curiosity to holistically look at the needs of individuals, not just solely based on what they are being told by the individual who may be being abused.

- 8. Bedfordshire Adult Social Care and Bedfordshire Police to integrate into their processes that communication must be made with each other in addition to referrals to exchange and deliberate information that is gathered when it is apparent that they are both responding to the same individual/household.**

This will negate the same concern being dealt with in isolation by agencies and ensure collaborative working and information sharing which will avoid assumptions being made.

- 9. Central Bedfordshire Domestic Abuse Service to oversee the incorporation of information and the understanding of the complexities of economic abuse within training and communications to professionals and organisations across the Central Bedfordshire area.**

This will broaden the knowledge of professionals to both identify and respond to those who may be receiving financial abuse.

- 10. A centralised register is required for all unpaid/unofficial carers to be recorded when they come to the notice of professionals, with a record of who is receiving care and who is providing that care in order to prevent 'hidden adults'.**

This will ensure that once a person cared for becomes known to a professional, a record will be made on who is their carer which will allow for both care and risk assessments, when necessary, due to the known correlation between domestic abuse and carers heightened risk.

