# Overview report

# 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 Abuse Related Death 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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## Preface

The key purpose of any Domestic Homicide Review (DHR) is to examine agency responses and support given to a victim of domestic abuse prior to their death and to enable lessons to be learnt where there may be links with domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death in this case met the criteria for conducting a DHR according to Statutory Guidance1 under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there 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 he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Domestic Abuse Act 2021 and the Home Office define Domestic Abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following—

(a) Physical or sexual abuse

(b) Violent or threatening behaviour

(c) Controlling or coercive behaviour

(d) Economic abuse

(e) Psychological, emotional or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a) Acquire, use or maintain money or other property, or

(b) Obtain goods or services.

For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Controlling behaviour is:

A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is:

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. The term domestic abuse will be used throughout this review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

Recommendations will be made at the end of this report, however, there has been an ongoing action plan introduced by the panel, parallel to this review to ensure that the areas that can be immediately addressed have not incurred unnecessary delay.

## Glossary

**DA –** Domestic Abuse

**CMIT** – CSE and Missing Investigation Team (Police)

**CSP –** Community Safety Partnership

**GP** – General Practitioner (Doctor)

**HMP** – His Majesty's Prison

**IDVA** – Independent Domestic Violence Advisor

**MARAC** – Multi Agency Risk Assessment Conference

**PIP** – Professionalising Investigation Programme

**SIO** – Senior Investigating Officer

**THRIVE** – Threat, Harm, Risk, Investigation, Vulnerability and Engagement

# Section 1 - Introduction

## 1.1 The commissioning of the review

**1.1.1** This review examines agencies responses, provisions and support available or provided to Bridget, a 74-year-old female living in the Central Bedfordshire area, prior to her death being established by Bedfordshire Police in April 2024. This report will explore the responses to calls for concern from family members and the scrutiny on unpaid carers as Bridget lived in her own home and had a 'lodger' who did not pay rent but took responsibility for caring for her following her suffering a stroke.

**1.1.2** The 'lodger', 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. It is believed that Bridget died in November 2023 on the admission of Cody.

**1.1.3** Bedfordshire Police made a referral to Central Beds Community Safety Partnership (CSP) in June 2024 due to the circumstances of the death and the fact that as Cody was living in the same address as Bridget. Later that same month, Central Beds CSP made a decision to undertake a Domestic Homicide Review (DHR) as the definition in section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

**1.1.4 Contributors to the review**

| 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 |

**1.1.5** 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

**1.1.6 Review Panel**

The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports and chronology. Individual Management Reviews (IMRs) have been requested and supplied:

**1.1.7** 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 |

**1.1.8** The Victim Support Homicide Service were asked to join the panel following observations from Brian (Bridget's estranged husband), but declined. All members of the panel and authors of the IMRs have complete independence from any subject in this review. The Review Chair and Panel gave due consideration for the content of the DHR and it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided. Thanks go to all who have assisted and contributed to this review with their valued time and cooperation.

**Author of the Overview report**

**1.1.9** 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.

**1.1.10** She has completed several training courses including the Home Office online training, the Continuous Professional Development accredited AAFDA 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 Home Office qualification of a level three certificate in Chairing a Domestic Homicide Review.

**1.1.11** Mrs Dadd has completed and published several DHRs.

## 1.2 Purpose of the review

The purposes of a DHR are to:

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

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

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for the Coroner and criminal courts, respectively, to determine as appropriate. DHRs are not part of any disciplinary inquiry or process. Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and domestic abuse. The review also assesses whether agencies have sufficient and effective procedures and protocols in place which were understood and adhered to by their staff.

This review will ascertain whether domestic abuse could have been the cause or a contributory factor to the death of Bridget. It is not to apportion blame, but to view the circumstances through her eyes.

## 1.3 Timescales

**1.3.1** Following the death of Bridget, Bedfordshire Police made a referral to Central Beds Community Safety Partnership (CSP) in June 2024 due to the circumstances of the death and the fact that as Cody was living in the same address as Bridget. Later that same month, Central Beds CSP made a decision to undertake a Domestic Homicide Review (DHR) as the definition in section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

The Home Office were notified later the same month. Mrs Jackie Dadd was commissioned to provide an independent Chair and Author for this DHR a few days later.

Three separate panel meetings then took place. The panel and family agreed and ratified the report and its findings and the completed report was handed to the Central Beds CSP on 20th June 2025.

**1.3.2** Table outlining timeline of review:

| | |
|---|---|
| April 2024 | Bedfordshire Police ascertained the death of Bridget |
| 14/06/24 | Bedfordshire Police make a referral to Central Beds CSP |
| 26/06/24 | Decision to commission a DHR made by Central Beds CSP |
| 26/06/24 | Home Office notified of the decision to commission a DHR |
| 07/08/24 | Mrs Jackie Dadd commissioned as Chair and Author |
| 18/11/24 | First Panel meeting |
| 11/02/25 | Second Panel Meeting |
| 04/04/25 | Third Panel meeting |
| 20/06/25 | Completed report handed to Central Beds CSP |

**1.3.3** Home Office guidance states that the review should be completed within six months of the initial decision to establish one. There was a significant delay in the completion of the commencement of the review due to awaiting the completion of the judicial process. The Home Office were made aware of this by Central Beds CSP.

## 1.4 Confidentiality

This report has been treated as Official Sensitive and dissemination kept to those outlined at 1.9.

The pseudonyms used in this report were chosen by the author and agreed by her family to protect the identity of those referred to throughout the report. Full details are found at 1.6 of this report.

The Central Beds CSP and Author have ensured that the collation of information and the information contained within this report complies with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

## 1.5 Terms of Reference

**1.5.1** The Full Terms of Reference can be found in Appendix A at the conclusion of this report. The Terms of Reference were discussed and agreed upon during the first panel meeting and was a working document throughout the review.

**1.5.2** 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.

**Methodology**

**1.5.3** The initial scoping was completed and it was evident that there had been minimal contact with agencies from either Bridget or Cody. The Senior Investigating Officer for the murder investigation attended the first panel meeting. IMRs were requested from those agencies that had recent communication with either Bridget, Bridget's family or Cody. Summary reports were requested by the remainder of agencies in relation to their response to the Terms of Reference.

**1.5.4** Family members were approached to gain further insight and information into Bridget's life and relationship with Cody.

**1.5.5** The Author sent a letter to the HMP in which Cody was incarcerated, inviting him to speak to her to gain the perpetrator's perspective. With his acceptance, she visited him there and his perspective can be found at 3.3 of this report.

**1.5.6** Three panel meetings were held in which the recommendations and action plan were ratified in the third panel meeting.

## 1.6 Subjects of the review/Family and friends' involvement

**1.6.1** 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.

**1.6.2** Central Beds CSP wrote to Brian informing him of the DHR and providing details of AAFDA and the Home Office leaflet 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. He helped form the Terms of Reference and formed some of the recommendations from the information he provided.

**1.6.3** 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. Both the Author and Central Beds CSP would like to thank Brian and Olivia for their contribution to the review which provided family context and information that led to some of the recommendations.

## 1.7 Parallel reviews

**1.7.1** There are no parallel reviews as the Criminal proceedings and Coroner's inquest were concluded prior to the commencement of this review.

## 1.8 Equality and Diversity

**1.8.1** The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. The relevant legislation that provided the context for the panel was The Equality Act 2010.

Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

**1.8.2** Key considerations for the panel were whether sex, age and disability had any relevant impact on the available services to Bridget and whether there were any barriers to accessing these.

**1.8.3** Bridget's sex was deemed relevant as one in four women experience domestic abuse in their lifetime[1] and 2.5 years is the average time victims at high risk of serious harm or murder live with domestic abuse before getting help[2]. There were 108 domestic homicides in the year ending March 2024[3] of which 83 were women. In the same dataset, 15 of those females were aged 65 to 74 years old and 18 of those females died from asphyxiation or strangulation.

**1.8.4** Age and disability were a consideration for the panel as due to her age, Bridget was deemed an elder person. She was not known to support services even though she had a stroke in 2020 as she was deemed to have capacity and she stated that Cody could look after her and cater for her needs. It is known that her mobility deteriorated, she suffered from depression and she had a certain reliance on smoking and alcohol yet none of these appear to have been specifically addressed and Cody was not recorded as a carer on any system with no assessments as to capability.

**1.8.5** The term 'carer' relates to both those who are in a paid profession and those who care for relatives or friends due to circumstance. Almost 1 in 10 people aged 85+ provide unpaid care. The UK does not publish a specific annual statistic for homicides committed by carers with the closest category to these circumstances being adult family homicides. The

[1] Domestic Abuse statistics UK - NCDV

[2] [2] SafeLives Insights Idva Dataset 2021-2022

[3] Homicide in England and Wales - Office for National Statistics

national Domestic Homicide Project reports 39 adult family homicides recorded between April 2023 and Maech 2024 but does not break down how many of these were acting in a carer role.

- Most carers over age 80 spend more than 50 hours per week caring. (A huge task for people whose own health may be deteriorating and whose caring role often goes unnoticed and unsupported.)
  (Ref: Caring together provided information and statistics in the area of older persons and carers)

**1.8.6** The Care Act 2014 put in place significant new rights for carers in England including:

- A focus on promoting wellbeing
- A duty on local authorities to prevent, reduce and delay need for support, including the needs of carers.
- A right to a carer's assessment based on the appearance of need.
- A right for carers' eligible needs to be met.
- A duty on local authorities to provide information and advice to carers in relation to their caring role and their own needs.
- A duty on NHS bodies (NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts) to co-operate with local authorities in delivering the Care Act functions.

**1.8.7** Equality is about ensuring everybody has an equal opportunity and is not treated differently or discriminated against because of their characteristics. Diversity is about taking account of the differences between people and groups of people and placing a positive value on those differences.

## 1.9 Dissemination

Recipients who received copies of this report prior to publication:

Bedfordshire Police and Crime Commissioner

Panel members at 1.1 of this report

Family members

Domestic Abuse Commissioner

Relevant members of Central Beds CSP

# Section 2 – The Facts

## 2.1 Background information

**Bridget (information provided by Brian)**

**2.1.1** Bridget was an only child from a small family and had a stable upbringing. She met Brian in the 1980's and they were married in 1992. Brian had a son, Richard, who grew up thinking of Bridget as his mother.

**2.1.2** They initially met in Redditch but moved to Hertfordshire where they owned a successful business. They separated in 2003 but remained married throughout due to financial reasons. Bridget moved to Bedfordshire in 2008 but Brian continued to support her by sending her £3000 per month to pay her bills and he paid her credit card, supporting her financially as per the agreement between them in the separation. They had a joint account the money would be paid into and then Bridget had her own account as well.

**2.1.3** Around 2013-2015 (Brian isn't sure of the exact time), Bridget met Cody by chance. He was a manager of a bar/kitchen in the social centre near to where Bridget lived. Cody stated that 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.

**2.1.4** At that time, friends describe Bridget as very capable, funny and sociable who liked having friends round the house and going out. She was the life and sole of the party and described as fiercely independent.

**Combined chronology**

**2.1.5** 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.

**2.1.6** 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.

**2.1.7** Up until 2022, Brian only had sporadic contact with Bridget over financial matters. Bridget owned a car that Brian paid for monthly. In October 2022, Cody took this car to Surrey (it is not known if he had permission) and abandoned it there with damage. It was five months before Brian discovered this and then had to arrange and pay for recovery,

repairs and cleaning. By this stage, Bridget was able to move around the house but was unable to drive and only left the house when someone was able to take her. She had a mobility scooter.

**2.1.8** In November 2022, Olivia contacted Social Services on more than one occasion to report concerns that she and Brian had in regard to Bridget, repeating the information that was provided to the police. They were emailed to the Adult Safeguarding Team as: Safeguarding Team received a telephone call from a member of the public named Olivia reporting concerns about Bridget towards an ex-partner.

**2.1.9** The reported concerns are summarised as:

- Olivia is in a relationship with Bridget's ex-partner (Brian) and Olivia was reporting that he continues to pay Bridget £3000 per month.
- Bridget lives in an apartment purchased by Brian and owes £9000 in unpaid property management costs.
- Bridget employs a private carer.
- The concern was around possible financial abuse

**2.1.10** It was recorded as a Safeguarding contact. A safeguarding initial Enquiry was undertaken and following a telephone call to Bridget it was recorded that Bridget denied concerns over financial abuse and explained that she had previously had financial assistance from Brian until Covid when his aerospace business collapsed. Bridget informed them that she had a live-in carer who was away at that time and that although she had a stroke three years ago, she has no unmet care needs and does not require an assessment.

**2.1.11** Bridget was given numbers for assessment, Age UK details for a cleaner and information on how to get support if required. It was finalised as no further action as no abuse was identified and therefore a decision was taken not to progress to a section 42 safeguarding enquiry.

**2.1.12** Olivia then contacted the police via phone and asked them to complete a welfare check on Bridget as she was elderly and they had not been able to get hold of her for about two and a half weeks. The mailbox was full and she informed them of Bridget's depression and disability since her stroke. Olivia had contacted Cody who stated that he was away and there was a fault on the line. He did not respond when they said that they were concerned and were going to contact the police and social services.

**2.1.13** Olivia explained her concerns to the police as she had to social services, in the fact that she relies on Cody for everything and that Bridget had recently been taken to court for non-payment of council tax which Brian settled and £9000 management fees outstanding on the property. Her bills were due to increase with a further £6000 to be paid. Brian knew that his monthly payments were enough to cover Bridget's bills and she had never owed money before. They were concerned that she was being taken advantage of.

**2.1.14** Local hospitals, Lister and Luton & Dunstable were checked and a THRIVE assessment completed. The THRIVE framework reminds officers and staff of the importance of

considering **T**hreat, **H**arm, **R**isk, **I**nvestigation, **V**ulnerability and **E**ngagement in all key decision making.

**2.1.15** Officer's attended Bridget's address and the log is endorsed that there were no concerns for Bridget, she was at home and was fine. Her carer was currently on holiday and she was ok with this. No referrals required and the neighbour was coming over to see her in the following half hour. Olivia was updated. Officers had no concerns and Bridget was safe and well at home.

**2.1.16** In June 2023, Bridget went into a nearby care home for rest bite and to ascertain whether this was somewhere she would want to live long-term. Brian had to sell his business and reduce his expenditure and after some time of discussing the sale of the house with Bridget, due to its expensive overheads, Bridget had agreed that it could be sold. Cody was aware that this was now a certainty and that Brian was going to deal with the sale of the house.

**2.1.17** In July 2023, the GP surgery sent Bridget a text message outlining the following:

'We are having to make the decision to ask patients who no longer reside within our areas to register with another surgery. The number of patients adding to our list is greater than we can support with the number of doctors we currently have. This affects the level of care we can provide. You can find the details of practices local to you by looking on the NHS Choices website under Find a GP and entering your post code. We are providing you with a polite notice of 30 days for you to register, after this you will be deducted from our patient list.'

**2.1.18** It is known that Bridget did not register with another GP Surgery and that her last medication request which she made regularly online was at the beginning of September 2023. 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.

## 2.2 Circumstances of the death of Bridget

**2.2.1** 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.

**2.2.2** At Christmas, members of the family received gift cards via email from Bridget's account as presents. Olivia explains that the family discussed this and were concerned as the language used in the emails was not that of which Bridget would have used. The emails had grammatical errors and Bridget used to be a 'PA' (Personal Assistant) and would not have made these. She was not answering her phone and they contacted Cody on Christmas Eve who stated that he had not heard from her and was crying down the phone.

**2.2.3** 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. She provided background history of Bridget including that she had no history of struggling with mental health or self-harm issues and that she had contacted the local hospital and she was not there. Olivia stated that the carer was the only person living at the address and that she had been told by Cody that she had left yet had not used her bank account.

**2.2.4** The contact operator liaised with her contact supervisor and subsequently advised SE that the incident does not come under the definition of a missing person and was advised to call back if any immediate concerns are raised.

**2.2.5** Following Olivia informing Cody that she had contacted the police; Cody rang the police four days later to inform them he had last heard from Bridget on Christmas eve.

**2.2.6** Brian and Olivia were not satisfied with the police response as they had tried everything they knew to contact her and 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.

**2.2.7** Olivia made a further call to the police stating that they were extremely concerned for Bridget, re-iterated the previous information they had provided and stated that they did not trust Cody and his explanation that she had left the property. This was brought to the duty inspectors attention and Bridget was declared a missing person and enquiries and management were handed to the Missing Person team.

**2.2.8** Five days later, a peer review was conducted by a senior ranking Detective in the Major Crime Unit (MCU) and a number of enquiries were suggested. Central Beds adult Safeguarding (SOVA) were contacted who checked their system and stated they have had no recent contact with Bridget. The last contact was in 2022 when there were concerns regarding her finances and unmet care needs. She was not open to any teams or safeguarding. Two notes were on the system relating to attempt to contact. They would conduct an ELFT (East London Foundation Trust) check to see if the mental health teams held any information. A request was made for GP details, or any medication and they stated they couldn't see any on their system.

**2.2.9** Six days after the peer review, the high-risk missing person investigation was declared a murder investigation as a 'no body' murder. Several days later, Cody was arrested on suspicion of the murder of Bridget.

**2.2.10** 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.

**2.2.11** Whilst in custody, Cody was seen by the Liaison and Diversion Service due to the nature of the offence. He was not previously known to mental health services. He was offered an assessment and refused. It is recorded in the noted that he appeared relaxed in mood and behaviour. Cody stated that he had never self-harmed or had thoughts of suicide and has no thoughts or plans to do so at the present time.

**2.2.12** 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.

## 2.3 Individual management reviews (IMRs)

### 2.3.1 Bedfordshire Police

Details of the police' response to calls made to them in regard to concern for Bridget's safety have been embedded throughout 2.1 and 2.2 of this report.

Good practice was shown in a learning review being completed. questionnaires being sent to relevant officers and staff including those carrying out the role of Senior Investigating Officer [SIO] or Deputy/SIO, Covert Authorities Bureau [CAB] staff, FCR line management, MCU SIO, SOCU supervisor and force silver at the time. The questionnaire detailed topics for comment including:

· investigation strategy once declared as a high-risk missing person. This can include the allocation of an SIO, handover between SIOs or any other aspect of the strategy.
· How the investigation was resourced, the numbers of resources, their skill set and where they came from
· Access to the right specialist support to the investigation?
· The Gold and Silver oversight supported/assisted/impacted on the progress of the investigation

A review of the calls made to the Force Control Room by Olivia was also conducted by a Chief Inspector with learning found relevant to individuals receiving those calls.

The contact the Police received from Olivia in November 2022 was the first knowledge and record of Bridget that the police had received.

In September 2024, the government announced that they will be introducing statutory guidance around their commitment to introduce Domestic Abuse Specialists within Police teams and within Police control rooms as part of Raneem's law.

Raneem's Law was introduced following the tragic death of Raneem Oudeh and her mother, Khaola Saleem, who were murdered by Raneem's ex-husband. Raneem called the police four times on the night of her murder but did not receive a response in time as her call was not graded for an immediate response.

Bedfordshire Police have agreed to be part of 'Phase 1' of this role whereby DA Specialists have been identified and deployed within the Force Control Room (FCR) to provide additional support, knowledge, assessment and guidance with victims of DA and the managing of DA incidents.

Bedfordshire Police went live with this initiative on Monday 10th February 2025. Being part of the Raneem's Law within the FCR is an important initiative to enhance the response to victims of domestic violence. Having an IDVA in the control room to help ensure a high standard of response is a crucial step toward better support and intervention.

By embedding a specialist directly into the process, this approach can help ensure that the victim receives a more informed and effective response from the start. It also allows for real time quality assurance and expert guidance which could make a real difference in safeguarding victims. Bedfordshire Police feel this may have assisted in the earlier identification of domestic abuse in the case of Bridget had the process been in place at that time.

### 2.3.2 GP Surgery

Bridget was registered with her GP surgery from 11/10/91 until 06/09/23. She was de-registered from the Practice on 06/09/23 due to being an out of area patient. The Practice, at the time, was in the process of removing patients from the Practice List who were out of the Practice catchment area, due to significantly increasing local patient population because of new housing. The patient was given 30 days' notice to re-register with an alternative GP Practice on 14/07/23. Bridget was also sent a letter and received a phone call but did not answer. No further follow-up was made.

At this time, 150 patients were removed, with all patients receiving either a text or email.

It must also be noted that the patient requested her medications online regularly until the patient was de-registered. The last medication request was made online by the patient on 05/09/23 and the prescriptions were issued by the Practice on the same day. Prescriptions were sent electronically to the patients nominated pharmacy.

Between May 2022 and September 2023, the Practice sent Bridget 22 text messages that were not responded to. These were in relation to requests for her blood pressure to be monitored at home due to her medication, vaccinations and screening. The Practice Manager states that she had responded and communicated regularly prior to 2022.

In addition, the following communication was made with Bridget during this time with no response:

Telephone: 08/02/23 regarding medication review

Email: 03/03/23 with a request to update contact details and ethnicity.

She last attended the surgery in July 2022 when she saw a Healthcare assistant. Bridget had not seen a Doctor since 2021.

## 2.4 Summary reports

### 2.4.1 Victim Support Homicide Service – National

Victim Support have both a local service and then, in the case of homicide, have a national service that provides support for families of those who have lost someone by homicide and a police investigation and criminal proceedings are taking place.

Once a referral is received to the service, a caseworker will be allocated and normally make contact via text to introduce themselves and to arrange a convenient time to phone/visit the client. A follow-up call is part of the process.

They would not normally allocate a caseworker with the same name as the deceased as they are aware that this could cause further trauma. This would appear to be human error on this occasion. Communication will be made to all staff to prevent a re-occurrence.

Records show that contact made with Brian shows a difference to the account that he has informed the author of and are content that correct procedure was followed in relation to the phone call. An informal complaint has been proceeded with internally due to the Author informing them of what they had been told by Brian during this review.

Brian provided consent in written form for his details on file to be provided for the DHR but Victim Support have stated that they do not feel that the service they provide post death is covered in the DHR statutory guidance[4] and have therefore not provided the information requested.

### 2.4.2 Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB)

The guidance for patient lists and de-registering a patient from a health practice is provided by NHS England[5]. Sections 3.2.7 to 3.2.16 detail the reasons for de-registering patients and the process to be followed and that consideration must be given to any potential safeguarding concerns to safeguarding either for children or vulnerable/at risk adults and that advice should always be sought from local safeguarding leads and/or the commissioners' designated professional.

The British Medical Association (BMA) also provides guidance[6]. The removal of a patient from a GP practice list should be a rare event. Reasons include:

1. disagreement between the practice and patient, and an irretrievable breakdown of the relationship

[4] DHR-Statutory-Guidance-161206.pdf
[5] https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/#3-managing-patient-lists
[6] https://www.bma.org.uk/advice-and-support/gp-practices/managing-your-practice-list/removing-patients-from-your-practice-list

2. the patient has died
3. the patient has moved outside the practice area
4. patients have a right to change their practice.

Deregistering a patient who does not respond – regarding the patient who has not responded to 22 attempts to contact them but still requests medication, this can be termed "an irrevocable breakdown in the relationship" between the patient and the practice. Therefore, deregistering the patient can be justified as long as the practice has documented the contact attempts and written to give the patient warning that they will be removed if they do not respond.

Where a practice wishes to remove a patient from its practice list, the practice must normally provide the reason for removal in writing to the patient. In the occasion where this is due to the patient living outside of the Practice area and the need to reduce numbers, a 30-day warning is required.

The ICB are content that the GP Surgery followed protocol when de-registering Bridget from their practice.

**2.4.3 Central Bedfordshire Domestic Abuse Service**

Following a recommendation from a previous DHR in their area, Central Bedfordshire have included domestic abuse and the heightened risk of identifying the vulnerability of carers to being either the abuser or subject to domestic abuse due to their role within the relationship into their Adult Carers Strategy 2022-2027 which is a reference to unpaid carers and not those paid to provide care and support.

A refresh of both paid and unpaid Adult Carers strategy is currently taking place in which they will now also include the recognition of those who live in the same household but do not have a relationship to be included and acknowledged as domestic abuse. They will also ensure this is included in their training across the area to professionals on domestic abuse which includes GP's.

**2.4.4 Lister Hospital – Hertfordshire**

In June 2020, Bridget self-presented at Lister Hospital as she had been experiencing weakness down her right-hand side and had experienced two recent falls. A CT scan of her head showed that she had suffered a stroke and had a mild decrease in coordination on that side.

Bridget was an in-patient for two days in which she saw a physiotherapist and was able to mobilise with a walking stick. she did quite well functionally and was able to take herself to the toilet and was 'self-caring' on the ward before discharge.

She had an early supported discharge pathway and had stated that her friend Cody was able to wash her and do the shopping so she did not have any unmet needs. She left with a

walking aid. It was noted that she had issues with alcohol and had been advised to stop smoking as this increased the risk of another stroke.

She was not recorded as having a carer and Cody's full details were not noted. There was no offer of a carer assessment and it was not felt that she required a home adjustment assessment. Bridget had obvious mental capacity and indicated that Cody would provide her support and this was not queried.

There is no vetting process for informal carers.

# Section 3 - Analysis

## 3.1 Family and friends' involvement and perspective

**Brian**

**3.1.1** Brian describes Bridget as slightly manipulative but states that nobody should lose their life in such a manner and states that he knew something was wrong for some time but nobody would listen.

**3.1.2** As the Next of Kin, Brian was contacted by the Victim Support Homicide Service by email to offer support during the criminal trial. There was no follow up until a further email was received informing him that his support worker had changed and the new caseworker had the same name as Bridget. Brian states that although he did not need the support, he is concerned that this could be very distressing for another family and is poor practice. He found them ineffective and a 'waste of space' and thought that their communication methods could be improved to make it more personal such as a phone call follow-up on the email. He was only ever contacted a couple of times.

**3.1.3** Brian states that his son, Richard and Bridget's cousin also contacted the police to try and report her missing in January 2024 and they were led to understand that they were all put on the same reference number and told they had been recorded but no action was initiated.

**Olivia**

**3.1.4** Brian and Olivia met in 2016 and eventually moved in together when Brian was diagnosed with a condition that sometimes effects his communication skills, so Olivia often makes contact on his behalf. This is the reason Olivia was the one that contacted the Police and ASC in regard to concerns over Bridget. Olivia acknowledges that there may have been some unconscious bias with Social Services when she explained who she was and felt this misconstrued the concerns she was raising.

**3.1.5** Olivia only met Bridget a few times, all after the time that she had her stroke. She states that Bridget could be 'feisty' and therefore, although it would have been beneficial for Adult Social Care and the police to go to Bridget's home to check on her, there was no

guarantee that she would have allowed them in or admitted anything was wrong as she was a strong woman. If they had done so, they would have found that the house was untidy and unclean with soiled incontinence pads lying around.

**3.1.6** This is what Brian and Olivia found when they went over to the house to see if she was ok as they were not content with the response from ASC. She believes that there may have been unconscious bias at the fact that she was the partner of Bridget's estranged husband and therefore, her concerns over financial abuse misconstrued as to the specific reasons for her concerns.

**3.1.7** Olivia states that she found it strange that a 40-year-old was 'sponging' off an elder lady and Cody appeared weak when she met him. He didn't seem a willing carer at her 'beck and call' and it is hard to say who was the manipulator out of the two of them. Having spoken to the neighbour, who was a good friend of Bridget, Cody only cooked ready meals in the microwave at times for her and Olivia stated how malnourished she looked.

**3.1.8** Olivia cannot understand how Cody 'slipped through the net' with ASC, having told them that he was Bridget's carer and does not understand why they did not record his details as such.

## 3.2 Terms of reference areas

**To establish if Domestic Abuse (DA) in any form had been the causation or contributory factor in the death of Bridget.**

**3.2.1** The act of suffocating Bridget with a pillow and killing her whilst being a member of the same household and being personally connected to her fits the domestic abuse definition and the definition for the commissioning of a DHR in itself. However, the panel have reviewed the behaviours that have been reported by friends and family to ascertain whether domestic abuse was occurring throughout the years leading up to Bridget's death.

**3.2.2** Although Bridget had advised the hospital staff following her stroke that Cody was capable of being her carer, the neighbour reports how he only ever fed her ready cooked meals from the microwave and not nutritional meals and it is stated by the family as to how malnourished Bridget looked. The panel have also taken into consideration Olivia's description of how dirty the home was and how there were soiled incontinence pads lying around the house.

**3.2.3** Although not a paid carer, Cody lived in the home rent free for over ten years. The above observations may be classed as neglect under the Care Act 2014 in which some of the ten categories of abuse mirror the abuse defined in the Domestic Abuse Act 2021 including emotional, psychological, physical and economic abuse.

**3.2.4** The malnutrition could be viewed as physical abuse as it links with the fact that Cody had possession of Bridget's credit card in order to do her shopping and although he admits to then using it for his own shopping s well, he explains this by way of stating that he didn't

want to cook separate meals and so it made sense to buy it all together. Bridget did not leave the house for a year prior to her death and infrequently left the bedroom during which time; Cody spent on the credit card leaving an outstanding balance of £8000.

**3.2.5** He also didn't take responsibility of his actions for selling property of Bridget's in 'cash for gold' as he states that she had previously told him that if anything happened to her, they would be his which was economic abuse as well as theft.

**3.2.6** Cody both exploited and abused Bridget's vulnerabilities and disabilities. The panel have taken into consideration that at the time of Bridget's death, he was aware that the house was going to be sold and that he would have to find alternative accommodation that he would have to pay for.

**What were the responses to calls for concern and were they effective?**

**3.2.7** Olivia first raised concerns about Bridget to Adult Social Care and the Police in November 2022 and clearly outlined the reasons for her concern. This incident was the first contact police had with any party in relation to Bridget. The information provided by Olivia highlighted some vulnerabilities that Bridget may have and the request was seeking confirmation of her wellbeing. This situation would now be addressed using the 'Right Care Right Person' response though at the time the operator correctly assigned a unit to establish Bridget's wellbeing.

**3.2.8** Olivia stated in the call she had initially informed social services who had told her to contact the police. Due to a number of disclosures during the telephone call, not least the understanding of the position of the carer, appropriate referrals should also have been made to social services.

**3.2.9** However, during the discussion of this point in the panel meeting, the representative of ASC stated that this would not have made any difference as ASC had already closed their enquiry as they were satisfied there were no care needs or cause for concern.

**3.2.10** The safeguarding support worker liaised with Bridget the information is limited to the notes in the case management system. On the notes, it shows that Bridget disclosed that although she had a stroke, she had no unmet care needs and that she had a private carer. The safeguarding support worker makes an offer of a Care Act assessment which is declined, as Bridget says she has no unmet needs. There is no description in the recording of the level of support being provided by the carer and no recording as to who was going to support Bridget with her care whilst the carer was away. The likeliness of a disclosure to Adult Social Care during a phone call needs to be questioned as there was no rapport or trust built and it would not have been known if Cody was in the background, preventing disclosure and potentially increasing risk.

**3.2.11** A more detailed description of what the live in carer did and recording the care support being provided may have been able to further identify what Bridget's care needs were. Also, this was a missed opportunity by professional's to record the details of the carer. There was no liaison between the Police and ASC although both knew that the other had been contacted by Olivia and had spoken to Bridget. (Recommendations refer)

**3.2.12** Following a call to the police in January 2024 by Olivia, stating that they had not seen Bridget for over a month and outlining several reasons for concern, professional curiosity should have raised questions to instigate some actions to establish that Bridget was alive and well. The fact someone was calling out of concern for a vulnerable person who had not been seen for over a month, reported as leaving with a stranger, and not accessed their bank account should have raised concerns.

**3.2.13** Olivia highlighted Bridget may be vulnerable due to suffering a stroke, was disabled and couldn't walk very far. The log details state that there is no trace of Bridget on computer systems yet thorough research would have identified the previous contact by Olivia and re-iterate the vulnerability concern for Bridget. This would have given more detail to the risk assessment as well as other information which would have assisted in any decision making. The minimum initial response should have been for Cody to have been seen and spoken to.

**3.2.14** Although the contact operator and her supervisor were of the opinion the circumstances did not fall into the category of a missing person, it clearly does. The THRIVE model was completed but the answers did not identify the concerns being raised. A learning de-brief was carried out by Bedfordshire Police which shows good practice and it was established that the initial call was dealt with by an inexperienced call-handler who concluded that Bridget had left her home of her own free will and was not a missing person. She sought advice from her supervisor who agreed.

**3.2.15** When the operator returned to speak to Olivia to tell her she would not be reporting her missing, Olivia then disclosed more information about Bridget's serious vulnerability and that the lodger, Cody was the only one who had seen her leave to stay with a friend. The operator has failed to respond to this new information and has maintained her position that this would not be recorded as a missing person. Following a conduct assessment, missed opportunities and learning points have been turned into a 'Practice Requiring Improvement' action plan for the operator.

**3.2.16** Following Cody's unexplained call four days later to state that he had not had any communication from Bridget since Christmas eve and that she had chosen to cut contact, the initial log was updated but as it was already closed, it did not alert anyone to this call. (Recommendations refer)

**3.2.17** The last time Bridget attended her GP practice was in June 2022 following a fall as a follow-up appointment from her having attended the Bedford hospital who sutured the cut on her forehead. Good professional curiosity is shown by hospital staff who enquired as to how the fall had occurred.

**Are policies and procedures effective in safeguarding those vulnerable to domestic abuse?**

**3.2.18** There is no national or local centralised carer record where professionals input information about care arrangements other than on the case management system. In this instance details for primary carer were not inputted into the case management system by the support worker. If there had been a centralised carer record for those carers who were

unpaid then this may have prompted an assessment of either Bridget's needs or Cody's and may have elicited information that would have provided more scrutiny rather than Bridget being a 'hidden adult' (Recommendation refers)

**3.2.19** The support worker was informed by Bridget that the police had undertaken a welfare visit. There is no record as to whether there was liaison with the Police to ascertain the outcome of their welfare visit. It may be that no contact from the police to the safeguarding team following the welfare visit was understood as no presenting issues but an assumption should not have been made in these circumstances.

**3.2.20** 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.

**3.2.21** The missing person procedure policy provides clear guidance and a definition of a missing person as 'Anyone whose whereabouts cannot be established will be considered as missing until located, and their well-being or otherwise confirmed.'

**3.2.22** The definition is deliberately wide and designed to allow individual forces, officers and staff to employ robust risk assessment. Rather than rely on the definition, the police should instead use the THRIVE model and the National Decision-Making Model (NDM) to decide whether or not it is appropriate for the police to respond and investigate taking into consideration the College of Policing Risk Principles. The definition alone should not dictate the police response. This was not suitably followed in January 2024 when Olivia contacted the police.

**3.2.23** Following Olivia's phone call to the police in April 2024, good practice has been identified with the peer review from MCU being carried out four days later to assist with the direction and appropriate enquiries to take which then led to it being declared a murder investigation. This request was timely and afforded with good practice as there was a suspicion from early on in the enquiry of third-party involvement and the investigation may become a criminal one.

**3.2.24** 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.'

**3.2.25** 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.

**Establish if economic abuse is identified by professionals and the safeguarding measures surrounding this area.**

**3.2.26** The correlation between Domestic abuse and a carer in the home has been acknowledged nationally as increasing the risk of abuse to either the carer or the person being cared for. This is poignant in relation to economic abuse and the opportunities presented for a carer to exploit the vulnerability of someone they may have a power of attorney for or in this case, the immobility of Bridget which meant that Cody had possession of her credit card to do the shopping and spent this up to £8000 being owed. He had access to Bridget's passwords and laptop as he was ordering her medication prescriptions online which provided him even more opportunity and exploit her trust in him.

**3.2.27** As Cody was not registered anywhere as a carer, Bridget remained a 'hidden' adult to professionals and therefore, this would not have been noticed. The only reason this was identified was due to her joint bank account and finances being entwined with Brian, yet even when Olivia outlined this as the concern, neither the ASC or the Police made enquiries with banks in relation to expenditure and ASC based their decision that there was no abuse identified from a phone call with Bridget who told them so, yet it may be that Bridget was not even aware. It is accepted that Bridget was mentally competent as told by Olivia and Brian.

**3.2.28** There is a process called a suspicious activity report that can be utilised between banks and the police to safeguard vulnerable persons finances but this was not considered on any of Olivia's reporting and finances were not looked at until a murder investigation commenced.

## 3.3 Perpetrator's perspective

**3.3.1** Cody was interviewed by the author in a face-to-face meeting in Prison.

**3.3.2** Cody states that he had previously worked as a carer and as a manager for children with life limiting disabilities in Hertfordshire, Luton and in the private sector but left due to the stress it caused him and he didn't return to that sector. He admits that he has always been a heavy drinker and has never sought help but knows where to go if he wanted to. No professionals knew of his drinking habits.

**3.3.3** Cody states that he lived rent-free with Bridget for the entire time that he lived in her home and tried to repay this by doing shopping and cooking meals. He felt a duty to Bridget, describing them as friends and states that even before her mini stroke, if he was out with friends, he would always leave early as he felt bad that she was home alone.

**3.3.4** Following Bridget's stroke, he states he tried to help her but it was demoralising as she was strong minded and wouldn't go to the Doctor or have a chair in the bathroom for some time. He felt he was against barriers. Bridget would hide away in her bedroom and say, "it's the stroke".

**3.3.5** Cody stated that he had possession of Bridget's credit card and did all of the shopping which he eventually admitted, included his own. He admits the taking of her jewellery and selling cash for gold but states that she had taken him around the house and pointed out items that he was to have if she ever died so 'technically, they were mine'. He told how Bridget bought items on QVC and that was why the bill was so high.

**3.3.6** He states that the neighbour helped at times but he didn't realise how bad he was feeling and in the last six months, started drinking more and more. The Author asked him if he knew where he could have gone for help and he showed good insight into Adult Social Care, Samaritans and Age concern but said that he didn't want to get help as he didn't want to admit that he couldn't look after her. It had gradually got worse and he didn't notice until he was at breaking point.

**3.3.7** He felt like he was a go between in relation to the property sale but states that he had friends he could go and stay with so this would not have been an aggravating decision towards his final actions. He states that it wasn't in a fit of rage or because he was drunk, it's just that he didn't want to deal with it anymore but didn't want to say that he couldn't. Cody states that a week before he killed Bridget, he aborted attempts where he stood at her bedroom door with a pillow and then went back to bed.

**3.3.8** Cody states that he covered up Bridget's death because he panicked and after six months, he was relieved when he was arrested.

**3.3.9** Cody now accepts on reflection, that due to his own issues, he was not the most suitable person to care for Bridget and that if authorities would have had his details on record and pro-actively contacted him to offer support, he may have been more inclined to accept the offer rather than reach out for it himself but states that nobody knew he was doing it as 'they' (e.g. GP,ASC) didn't ask.

# Section 4 – Conclusions and Recommendations

## 4.1 Conclusions

**4.1.1** 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.

**4.1.2** 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.

**4.1.3** 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. A visit to her home may have identified potential neglect as witnessed BY Brian when he saw the state of the house.

**4.1.4** 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.

**4.1.5** 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.

**4.1.6** 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 acknowledge, 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.

**4.1.7** 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.

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.

**4.1.8** 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.

**4.1.9** 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.

**4.1.10** 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 accruement 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.

**4.1.11** Health professionals advised Bridget of her excessive smoking and drinking following her stroke but there is no record of any referrals or offers of assistance to reduce or abstain from either. This was a missed opportunity to improve her health and capabilities.

**4.1.12** 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.

## 4.2 Lessons to be learnt

**4.2.1 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 or if the risk was heightened due to the phone call.

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.

**4.2.2 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.

There is a requirement for a central record of unpaid carers, whether local or national which means that there would be a professional support mechanism for them and they would not go unnoticed.

## 4.3 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 and consider a home visit, 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.

# Appendices

## Appendix A

### Terms of Reference

- 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.