

Domestic Homicide Review Overview Report:

Jean Redfern

(Born: 4th January 1946)

and

Sarah Redfern

(Born: 29th May 1980)

Both died on 22nd July 2013

Paul Johnston

Director: Johnston and Blockley Ltd

26th November 2014

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| **1** | **Introduction** |
| 1.1 | This Domestic Homicide Review Overview Report relates to the deaths of Mrs Jean Redfern and her daughter Sarah Redfern in their home at Wath-on Dearne, Rotherham on 22nd July 2013. |
| 1.2 | Peter Redfern (Jean’s husband and Sarah’s father) was arrested and in January 2014 he pleaded guilty to the manslaughter of Jean and the murder of Sarah. He was sentenced to 12 years and life imprisonment respectively. |
|  | **Family wishes** |
| 1.3 | It is the firm wish of the relatives of Jean and Sarah Redfern that they be identified by name throughout this report. Because Peter Redfern was convicted of the killings and his name is already in the public domain, they feel he also should be named. |
|  | **The circumstances of Jeans and Sarah’s deaths** |
| 1.4 | Shortly before 7pm on 22nd July 2013, the police received a 999 call from Peter Redfern. After giving his name and address, he said he had killed his wife and daughter. He was calm, but terminated the call when he was asked further questions by the call handler. |
| 1.5 | The police went straight to the address and found Peter Redfern in the garden in an apparently dazed and confused state. They found the bodies of Jean and Sarah in the house. Jean had been suffocated and had a plastic bag over her head which had been secured with a length of tightly knotted electrical flex. Sarah had been struck repeatedly over her head with a hammer. A plastic bag, tied with flex, had also been placed over her head. |
| 1.6 | Peter Redfern was arrested for murder but he declined to answer any questions when interviewed by the police. He refused to eat or drink and as a precaution, he was taken, whilst still in custody, to hospital. He was later discharged back into police detention. |
| 1.7 | He was charged with murdering Jean and Sarah and subsequently appeared at Rotherham Magistrates Court on 24th July 2013. He was remanded in custody pending trial. |
| 1.8 | On 15th January 2014, he appeared at Sheffield Crown Court where he pleaded guilty to the manslaughter of Jean and the murder of Sarah. He was sentenced to 12 years imprisonment for manslaughter and life for murder, of which he must serve 17 years before eligibility for parole. |
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| 1.9 | The following is an excerpt from the sentencing remarks of the trial Judge:  *‘...You married your wife in 1968 and lived all 45 years of your married life at [address redacted] in Wath. Your daughter Sarah was born in 1980 and so was 33 when you killed her. She was your only child. The three of you formed a close and reserved family unit with little or no outside social life. To all appearances you were a loving, self sufficient and contented family with no known problems or conflicts.*  *You are now aged 70 having retired some years ago from your job as a gas fitter, a job which you held all your working life. In May 2013 you were diagnosed with multiple myeloma, a form of bone cancer which is incurable. You underwent chemotherapy and participated in a national trial for treatment with particular drug combinations, but this produced unpleasant side effects which led to you ceasing this treatment. I need to emphasise that according to the information which I have been given, the drugs which you took were not in any way experimental but were recognised drugs. The nature of the trial was to determine the most effective combination of such drugs for treating your form of cancer. Studies have shown, however, that in a very small percentage of cases the drugs which you took can lead to an adverse psychiatric reaction, which when it occurs is generally mild or moderate but in a very small number of cases can be serious. Tragically, that was to prove to be so in your case.*  *On 22 July you were at home with your wife, while your daughter was at work. At some point in the afternoon you killed your wife by strangling her. When her body was found by the police, there was a plastic carrier bag over her head, secured with white electrical flex wrapped round her neck and knotted tightly at the front. It is not clear whether you strangled her with this flex or, as I understand to be your case, you strangled her with your hands and put the bag over her head afterwards, using the flex to secure it. Why you would have done this if you did strangle her with your hands is a mystery which you have not explained.*  *The prosecution have accepted that your killing of your wife constituted manslaughter on the basis of diminished responsibility. They have done so on the basis that there is expert medical evidence to the effect that as a result of the drugs which you had been taking you were suffering from depression, which is a recognised medical condition, that this can lead to impulsive conduct and impairment of judgement, and that on the balance of probabilities you killed your wife on impulse when your mental functioning was abnormally affected in this way. Precisely how or why this happened may never be known.*  *After you killed your wife, you realised that your daughter Sarah would be coming home from work and would see what had happened to your wife, to whom she was particularly close. They have been described as “best friends” as well as mother and daughter. You decided that this could not be allowed to happen. When Sarah arrived home you surprised her, with a carrier bag, electric flex and hammer which you had got ready for use. After managing to put the carrier bag over her head, you killed her by hitting her repeatedly on the head with severe force. In her case too, the bag was secured with the flex.*  *You then changed your clothes and made a telephone call to the police in which after giving your name and address you said, “I’ve just killed my wife and daughter”.*  *Although the life style which you and your wife and daughter had chosen means that they did not have many friends, it is important to recognise that they do not go unmourned. There are other family members who loved them and miss them, and will continue to do so. Nothing I say or do can restore the loss which your conduct has caused, or can fill the gap which has been left. I have taken into account in particular the dignified and generous statement of Jean’s brother, Sarah’s uncle, who describes the impact which their deaths has had on him and his struggle to understand what happened on that dreadful day...’* |
| **2** | **Establishing a Domestic Homicide Review** |
|  | **Strategic Governance** |
| 2.1 | Rotherham is a metropolitan district in the county of South Yorkshire and has a population 258,400. It has a very diverse mixture of people and cultures. The majority of Rotherham’s residents live in urban areas, with 50% living near Rotherham town centre and 38% living in smaller rural towns such as Wath on Dearne which is on the south side of the Dearne Valley. At the time of the 2011 census, Wath on Dearne had a population of 33,500. |
| 2.2 | Strategic governance for domestic abuse and issues linked to the national Violence Against Women and Girls Agenda in Rotherham is held by the Safer Rotherham Partnership (SRP), which is the statutory community safety partnership for Rotherham. The work of the Safer Rotherham Partnership in relation to domestic abuse is supported by the local authority’s Safeguarding Adult’s Service, which provides operational management for domestic abuse coordination and Independent Domestic Violence Advocacy Service provision. |
| 2..3 | Domestic Abuse is one of the four priorities of the Safer Rotherham Partnership and this is set out in the Joint Strategic Intelligence Assessment under the heading “Reducing the threat of harm to victims of domestic abuse, stalking and harassment, ‘honour’ based abuse and forced marriage”. The work in relation to domestic abuse is undertaken on behalf of the SRP Domestic Abuse Priority Group (DAPG), which ensures the work of the Rotherham domestic abuse sector complies with the national agenda to ‘End Violence Against Women and Girls’. The DAPG provides strategic direction for the work of this sector and operational management of the Rotherham Multi Agency Risk Assessment Conference (MARAC). The strategic approach ensures a coordinated response to victims of domestic abuse in the support and protection of victims while holding perpetrators to account though delivery against the following themes:   * Prevent * Protect * Pursue |
| 2.4 | These themes provide focus to the sector’s work in encouraging victims to disclose abuse and in the longer term reduce repeat victimisation.  Rotherham is seeing an increase in referrals each year and is expecting this trend to continue. |
| 2.5 | The SRP delegated the review process in line with the 2011 guidance to DAPG. DAPG commenced this role by undertaking a desktop review by the Domestic Abuse Coordinator to ensure that all domestic abuse policies within the partnership were contemporaneous and all policies included the requirement to risk assess domestic abuse cases. This was completed in June 2012. |
| **3** | **The lead-up to the deaths of Jean and Sarah** |
| 3.1 | Peter Redfern had visited his GP in September 2012 suffering from back pain. He was treated with analgesic pain killers. He went back to the doctor in November because there had been no improvement and was referred to hospital for X-rays. These showed fractures to three of his vertebrae and he was sent to the Orthopaedic Department of Rotherham District General Hospital. He underwent several examinations including MRI and bone density scans culminating in a referral to the haematology department where a bone marrow biopsy was arranged. On the 11th June 2013, he was told a diagnosis of myeloma had been confirmed. He was informed that his condition was incurable but that it was treatable. On 13th June he commenced a course of chemotherapy. |
| 3.2 | Five days later, he attended the haematology clinic complaining of a rash that had developed due to the chemotherapy. His medication was changed and arrangements were made for him to re-attend the following week. |
| 3.3 | On 25th June he was seen again; his rash had improved and he was feeling much better. He was advised to continue with one of the drugs he had been prescribed and to self-refer if he experienced any further complications. Again, arrangements were made for him to be seen the following week. |
| 3.4 | On 4th July 2103 he went to the haematology outpatients department complaining of dizziness, anxiety, intermittent confusion and a lack of sleep. He said he wanted to discontinue the drugs trial and he was advised to cease his medication altogether. He was given a follow up appointment for the following week. |
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| 3.5 | He was seen again on 11th July and was told that blood tests had shown there to have been some positive results from the medication he had been taking. He expressed a preference for, and was started on a different drugs regime and was again told to self-refer in the event of any side effects. He was given a three week follow up appointment. |
| 3.6 | Five days later, on 16th July, he telephoned the hospital to say he was experiencing more side-effects. He was told to stop all medication and that his case would be discussed at a multi-disciplinary team meeting. |
| 3.7 | On 22nd July 2013, he was contacted by telephone by the hospital to ask him to attend an appointment at 9.30am on 24th July to see the consultant. After complaining that the appointment time was rather early in the morning, he agreed to attend. |
| 3.8 | He killed Jean and Sarah later that afternoon. |
| 3.9 | The following day, while in police custody, he was admitted to the Accident and Emergency Department of the hospital. He said he had been unable to eat or drink for 20 hours but did not know why. He was calm and coherent, and after routine blood tests was discharged back into police custody. |
| 3.10 | On 23rd July 2103, in line with agreed protocols, the police formally notified the Safer Rotherham Partnership of Jean and Sarah’s deaths. |
| 3.11 | On 1st August 2013, the Safer Rotherham Partnership Consideration Panel met and agreed that Jean’s and Sarah’s deaths clearly fell within the criteria of domestic homicide. The Panel was briefed about the police investigation to date which indicated there had been no prior history of domestic abuse or issues linked to mental health, alcohol and/or substance misuse. It was noted that Peter Redfern had recently undergone medical treatment which may or may not have had something to do with the events of 22nd July. |
| 3.12 | The Consideration Panel decided that even though there had been no known history of domestic violence or abuse within the family unit, the appropriate course of action, given the unusual circumstances of the killings and level of violence used by Peter Redfern, would be to commission a Domestic Homicide Review that would be guided by, and be proportionate to, any information that may come to light. The Safer Rotherham Partnership Executive Board agreed and the Home Office was notified accordingly. |
| 3.13 | The Safer Rotherham Partnership acknowledges that not all timescales laid out in the Home Office guidance for a DHR have been adhered to. This is due firstly to the lengthy criminal justice process and secondly in overcoming legal issues associated with gaining access to medical reports about Peter Redfern’s medical condition at the time he killed his wife and his daughter. |
| 3.14 | The review has concluded that none of the agencies that make up the Safer Rotherham Partnership could have done anything to anticipate or prevent the tragic deaths of Jean and Sarah. The only agencies that Jean and Sarah were known to were their GP and the local hospital trust. Their engagement with them was in respect of routine health matters. Peter Redfern had been involved only with the same two organisations, in respect of routine health matters and for his treatment of the multiple myeloma. |
| 3.15 | None of the family of Jean, Sarah or Peter Redfern nor any of their friends or work colleagues ever had any cause to consider that domestic violence or abuse may have been a feature of their lives. |
| 3.16 | Expert medical opinion is that the care Peter Redfern received in connection with his diagnosis and treatment of multiple myeloma was excellent and appropriate. The medical notes indicate that he was not taking any medication for a period of 6 days prior to 22nd July and the view of an internationally renowned Consultant haematologist and Professor of haematology is that it is very unlikely that the steroids he had been taking would have had any effect on him that day. |
| 3.17 | Why Peter Redfern did what he did to his wife and daughter on that fateful day remains a mystery. Through his solicitor, Peter Redfern has been invited to participate in this review but, at the time of writing this report, no response has been received. |
| **4** | **The purpose of a Domestic Homicide Review** |
| 4.1 | The purpose of a DHR is to:   * 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 * 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 * Apply these lessons to service responses including changes to policies and procedures as appropriate * Prevent domestic violence and abuse homicide and to improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-agency working. |
| 4.2 | A DHR is not an inquiry into how the victims died or what the motivation was behind their deaths. Those are matters for coroner and the judicial system to determine. |
| 4.3 | DHRs are not specifically part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates that disciplinary action may be initiated by a partnership agency, the agency’s own disciplinary procedures will be undertaken and will be separate to the DHR process. |
| 4.4 | The rationale for the review process is to ensure that agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide and violence. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees. |
| **5** | **Terms of reference for the review** |
| 5.1 | The review will:   * Seek to establish whether what happened on 22nd July 2013 could have been predicted or prevented * To seek to understand the dynamics within the Redfern family and subject to any information that emerges, to review any incidents or events that appear to be relevant * To request Individual Management Reviews from any agency that had involvement with Jean and Sarah and with Peter Redfern prior to 22nd July 2013 * Seek the involvement of the family, employers, neighbours and friends to provide a robust analysis of what happened * To seek the involvement of Peter Redfern in the process * Take account of coroners or criminal proceedings in terms of contact with the family, employers, neighbours and friends and with Peter Redfern * Produce a report that summarises the chronology of the events, including the action taken by any agencies involved, that analyses and comments on what they did, and that makes recommendations about the safeguarding of victims of domestic abuse * Undertake an assessment of the Partnership’s existing procedures and protocols to ensure they are robust, reflect good practice and are understood and adhered to by staff * Undertake a review of recent and current awareness raising in relation to domestic abuse to ensure that all victims and those who may be aware of it know how to contact agencies. |
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| 5.2 | The review identified the following general areas for consideration:  **Family engagement**   * How should friends, family members and other support networks and, where appropriate, Peter Redfern, contribute to the review and who should be responsible for facilitating their involvement? * How matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for it? |
| 5.3 | **Legal processes**   * How will the review take account of a coroner’s inquiry, and (if relevant) any criminal investigation related to the homicides, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process? * Does the review panel need to obtain independent legal advice about any aspect of the proposed review? |
| 5.4 | **Research**   * How should the review process take account of lessons learned from research and previous DHRs? * In order to reach a view on whether Jean and Sarah’s death could have been predicted and/or prevented, each IMR author was asked to include information on and analysis of, all the following issues: |
| 5.5 | **Diversity**   * Are there any specific considerations around equality and diversity issues, such as ethnicity, age and disability that may require special consideration? |
| 5.6 | **Multi agency responsibility**   * Was Jean or Sarah subject to a Multi Agency Risk Assessment Conference? * Was Peter Redfern subject to Multi Agency Public Protection Arrangements? * Was Peter Redfern subject of a Domestic Violence Perpetrator Programme? * Did Jean or Sarah have any contact with a domestic violence organisation or helpline? * Were Jean, Sarah or Peter Redfern ‘vulnerable adults’? * Were there any issues in communication, information sharing or service delivery between services? |
| 5.7 | **Individual agency responsibility**   * Was what took place consistent with each organisation’s policies and procedures for safeguarding and promoting the welfare of adults and with wider professional standards? * What were the key relevant points/opportunities for assessment and decision making in relation to Jean and Sarah and to Peter Redfern? * What was the quality of any multi-agency assessments? * Was the impact of domestic violence on Jean and Sarah recognised? * Did actions accord with assessments and decisions made? Were appropriate services offered/provided or were relevant enquiries made, in the light of assessments? * Was there sufficient management accountability for decision making? * Were senior managers or other organisations and professionals involved at points where they should have been? |
| 5.8 | **Case specific issues**  In addition to the terms of reference that are set out in the revised Home Office statutory guidance, the Review Panel considered the following should be examined:     * Whether the drugs prescribed to Peter Redfern after his diagnosis of multiple myeloma could have been a causative factor. * The information that was given to Peter Redfern at the time of his prognosis and during his treatment * The information sharing processes between Peter Redfern’s GP and The Rotherham Foundation Trust (TRFT), after Peter Redfern had been diagnosed with myeloma. |
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| 5.9 | **Additional issues**   * Issues that relate to ethnicity, disability or faith which may have a bearing on this review * Other DHRs in the region or nationally which are similar, and the availability of relevant research. |
| **6** | **Methodology** |
| 6.1 | This overview report has been compiled from analysis of the multi- agency chronology, the information supplied in the IMRs, the supplementary reports including medical opinion, court documents, interviews conducted by the DHR panel, consideration of previous reviews and findings of research into various aspects of domestic abuse. |
| **7** | **Participating Agencies** |
| 7.1 | The only agencies to have any contact with Jean, Sarah or Peter Redfern prior to the 22nd July 2013 were their General Practitioners and The Rotherham Foundation Trust (TRFT). |
| 7.2 | Both were required to produce:   * A chronology of their interaction with Jean, Sarah or Peter Redfern   and to indicate:   * What action was taken * Whether internal procedures were followed * Their conclusions and recommendations. |
| **8** | **DHR Panel Chair and Overview Report Writer** |
| 8.1 | The consideration panel requested tenders from suitably qualified people to act as Chair and Overview Report author for the DHR. Following a competitive process, Johnston and Blockley Limited was commissioned to fulfil both roles. |
| 8.2 | One of its partners, Mr Paul Johnston, undertook the role of Chair and Overview Report Writer. He is a specialist independent consultant in the field of homicide investigation and review. He has senior management experience in numerous aspects of public protection. He has been involved in several homicide reviews throughout the UK and abroad and has also been involved in many DHRs. He is currently a special advisor to a 3rd sector organisation that provides domestic abuse services (not in the area covered by the Safer Rotherham Partnership). |
| **9** | **The DHR Panel** |
| 9.1 | The consideration panel agreed the formation of a bespoke panel comprising of agencies that had dealings with Jean, Sarah and Peter Redfern before, during or after 22nd July 2103 albeit none of the contact had been associated in any way with domestic violence or abuse. |
| 9.2 | The DHR Review Panel consists of:   |  |  | | --- | --- | | * Paul Johnston | Chair and Report Writer | | * Steve Parry | RMBC Safer Rotherham Partnership Manager | | * Jan Bean | RMBC, Safeguarding Adults & Domestic Abuse Manager | | * Cherryl Henry-Leach | RMBC, Adult Safeguarding Domestic Abuse Co-ordinator | | * Jo Abbott | Public Health Consultation – Health Protection | | * Catherine Hall | The Rotherham Foundation Trust (TRFT) | | * Pete Horner | South Yorkshire Police Public Protection Team | | * Jean Summerfield | The Rotherham Foundation Trust (TRFT) | | * Ruth Fletcher-Brown | RMBC Public Health | | * Dr Ken McDonald | NHS Barnsley | |
| 9.3 | Family members, friends and colleagues of Jean and Sarah were invited to participate in the review process, but were not invited to attend the panel meetings in line with good practice identified during local serious case reviews. As mentioned previously, through his solicitor, Peter Redfern was invited to engage with the review but to date he has not responded. |
| 9.4 | The review panel met on the following dates:  Tuesday 20 August 2013  and  Friday 15 August 2014 |
| 9.5 | The agenda for each meeting was appropriate; there was a good level of debate and appropriate challenge, themes were identified and recorded as they emerged and the minutes and actions were promptly circulated and the latter closely monitored. |
| 9.6 | South Yorkshire Police provided updates about the progress of the murder investigation and briefed the Overview Panel about the circumstances of Jean and Sarah’s deaths. Helpfully, they identified which witnesses were likely to give evidence during the subsequent trial so that informed professional judgements could be made about interviewing people during the review. |
| 9.7 | On the basis of the information supplied by the police, the panel agreed it appropriate to defer the DHR until the ongoing criminal proceedings had been concluded so as not to risk compromising the judicial process. |
| **10** | **Parallel processes** |
| 10.1 | **Inquest / Criminal Investigations**  There was a thorough police investigation into the circumstances of the deaths of Jean and Sarah and a subsequent criminal trial. Peter Redfern pleaded guilty to the manslaughter of Jean and the murder of Sarah. He was sentenced to 12 years imprisonment and life imprisonment respectively. He must serve at least 17 years before being eligible for consideration of parole. |
| 10.2 | Although Jean and Sarah’s deaths were reported to the Coroner, no inquests will take place because all the evidence and information about the circumstances of their deaths was aired during the criminal proceedings against Peter Redfern. |
| **11** | **The Involvement of family members** |
| 11.1 | **Family Composition**  Peter Redfern  Jean Redfern  Sarah Redfern |
| 11.2 | The panel agreed that the review would benefit from the involvement of family members and friends; it was recognised that they may have an important role to play especially as none of the agencies knew anything about the lifestyles of Jean or Sarah or of Peter Redfern. |
| 11.3 | Letters were sent to the family members that had been identified by the police to formally tell them about the Domestic Homicide Review, what it entails and to invite them to take part in it. They were also told about the decision to defer the review until the ongoing criminal proceedings had been concluded. |
| 11.4 | After Peter Redfern had pleaded guilty to killing Jean and Sarah, the family members were contacted again and kindly agreed to take part in the review. |
| 11.5 | Mrs Julie Stone, Jean and Sarah’s niece, said she enjoyed a close relationship with them both and that there had never been any discussions or even signs of either being affected by domestic violence or abuse. |
| 11.6 | She said that Jean and Sarah did everything together and were mutually supportive of one-another. She considered Peter Redfern to be someone who kept himself to himself and that he was not someone you could get close to. She described both Jean and Sarah as being shy but very warm people; they would do anything for their friends and family. |
| 11.7 | Mr Colin Randerson (Jean’s brother) and his wife have come to accept that they may never know why Peter Redfern killed his wife and daughter. Since Peter Redfern went to prison, Mrs Randerson has written to him every month. Although she has not received a written reply, he has expressed his gratitude for the letters through his solicitor. |
| 11.8 | Mr Randerson said he accepted that no-one knows what goes on behind closed doors, but added that he had never seen Peter Redfern utter even an angry word in the 45 years he had known him. He said he was always a very ‘measured’ individual. He firmly believes that what happened to Jean and Sarah could not possibly have been predicted by anyone. |
| 11.9 | Mrs Randerson said that although she wouldn’t describe their relationship with the Redfern’s as being close, she knew she could call on them at any time without notice. When they did so, Peter Redfern would always answer the door and would make them most welcome. |
| 11.10 | Mrs Randerson said that they did not know much about Jean, Sarah or Peter Redfern because they led such insular lives. She said she thinks they preferred to close themselves off from the rest of the world and that they stayed in their ‘own little bubble’ rather than having to face all the bad things that happen throughout the world. |
| 11.11 | Mr and Mrs Randerson added that none of the Redfern’s were ‘touchy feely’ people and that they were very reserved. Mrs Randerson said that she thought Peter Redfern may at times have been lonely because Jean and Sarah were very close to one-another. |
| 11.12 | Both Mr and Mrs Randerson described Peter Redfern as being a very quiet person who did not go out very much. He appeared to prefer his own company. They said he was undoubtedly an intelligent, knowledgeable and well-read person. Mr Randerson said that in hindsight, he did wonder whether Peter Redfern may have been depressed before the diagnosis of cancer. |
| 11.13 | They said that Peter Redfern would always eat alone in the kitchen while watching television and that he liquidised most of his food. Jean and Sarah would eat together in another part of the house. |
| 11.14 | Mrs Randerson recalled that Peter Redfern was fanatical about his health and about personal hygiene. She said that a few years ago he would go for a run every day and in more recent years he would use a treadmill. |
| 11.15 | Mr and Mrs Randerson visited the Redferns’ at home the day after Mrs Redfern had telephoned with the news about the cancer diagnosis.  Mrs Randerson said Peter Redfern looked like a ‘little boy lost’. She said that as time went on, he lost a lot of weight and that he looked very frail the last time they saw him which was shortly before he killed Jean and Sarah. |
| 11.16 | The only other relations identified by the police during their enquiries were two cousins of Peter Redfern. They had not had any contact with him for 15 and 30 years respectively and could offer nothing of value to the investigation. Having consulted with the police, the panel chose not to seek to interview them as part of the review. |
|  | **Other avenues explored** |
| 11.17 | In an attempt to understand the motive behind the killings of Jean and Sarah, a significant focus of the police investigation was to examine the relationship that existed between them and Peter Redfern. To that end the police traced and interviewed numerous friends and former work colleagues of all three. The police have helpfully briefed the panel about the background information they gleaned during this process. |
| 11.18 | None of those spoken to by the police had ever had any cause to consider there may have been any issues of violence or abuse within the Redfern family unit. Some had known Jean, Sarah and Peter Redfern for nearly 30 years. They were regarded as a nice, polite family and one that very much kept themselves to themselves. |
| 11.19 | Work colleagues of Sarah said that she was extremely close to her mother and that she loved being in her company. Sarah had said that she enjoyed shopping with her mum but preferred her dad not to be with them, although she did not say why. The general feeling among Sarah’s work colleagues was that Sarah’s father went for a coffee while the two women were shopping. |
| 11.20 | They all said that Sarah was a very reserved individual who kept herself to herself. Although she would generally be reluctant to initiate a conversation, she would always respond if someone asked her anything. She was an extremely polite person. |
| 11.21 | One work colleague in particular said that Sarah was an uncomplicated person. She particularly liked costume jewellery and loved good quality shops, but other than that she appeared to live a simple life and was always with her parents when not at work. |
| 11.22 | One friend said that when they had agreed to meet away from work, she would specifically ask Sarah not to bring her mother with her. |
| 11.23 | She did not know very much about Sarah’s home-life, but did know that when the family went on holiday to Whitby (a couple of times a year), they would never stay for a full week. They would always go to the same hotel and even ask for the same room if they could get it. Sarah told her that her father always had his food blended before he ate it and that Sarah and her mother lived on microwave meals, even on Christmas Day. |
| 11.24 | The police did not identify any other friends that Sarah may have had outside the work environment. |
| **12** | **Summary of what was known by agencies and professionals** |
|  | **Jean and Sarah** |
| 12.1 | The only agencies that had any involvement with either Jean or Sarah were their General Practitioner and Rotherham hospital. This was in respect of routine medical matters that bore no significance to this review. There were no concerns or information whatsoever about domestic violence or abuse. |
|  | **Peter Redfern** |
| 12.2 | Peter Redfern was not known to any of the Safer Rotherham Partnership agencies other than to his GP and to the hospital where he was receiving treatment for multiple myeloma. Other than his short admission to hospital while in police custody after he had been arrested for murder, none of the contact had anything to do with issues of violence or abuse. |
| **13** | **Analysis of how and why events occurred** |
| 13.1 | There were no independent witnesses to what happened to Jean and Sarah on 22nd July 2013 and no-one spoken to during the police investigation or this review had any cause to suspect that anything untoward would happen to them. |
| 13.2 | The court was told that Peter Redfern had been retired for 17 years and had not worked since then because his family had all the money it needed. He had taken up cross-country running and had otherwise occupied his time with gardening and shopping. He had told a Consultant Psychiatrist that he had little contact with anyone outside his family except for occasionally visiting a social club and spending time with a couple whom he and Jean used to see on a regular basis (the police investigation did not identify this couple). The court was told that he was not someone who needed the company of others and that he was content to be on his own. He also told the psychiatrist that he had enjoyed a comfortable lifestyle and that although he had the money, he did not buy anything unless they really needed it. |
| 13.3 | The court was told that Peter Redfern considered his marriage to Jean had been a happy one and that had Jean wanted more than one child then it wouldn’t have been a problem to him. The court also heard that the Redfern family did not spend a lot of time away from home and had never been abroad. Peter Redfern’s hobbies were gardening, watching television and conducting research on the internet. |
| 13.4 | Peter Redfern also told the psychiatrist that he considered his intake of alcohol to have been moderate and that he would consume only a couple of cans of beer at night and a pint of beer at lunchtime. |
| 13.5 | He said he had had no major medical problems throughout his life and on the rare occasions when he did think there was something was wrong with him, he would see a doctor about it. He had added that he had not been particularly worried about his health until the diagnosis of multiple myeloma. |
| 13.6 | The court was told that Peter Redfern considered he had handled the diagnosis of multiple myeloma well and that although he had been upset, it hadn’t had a massive effect upon him. |
| 13.7 | He had said that he had been offered treatment in a myeloma trial and had agreed, but adverse symptoms had affected him all at once; he had become distressed, confused and had nightmares and a feeling of terror. He had therefore ceased taking the medication altogether on 16th July. |
| 13.8 | He had said that after the diagnosis, Jean and Sarah had tried cheering him up as had a neighbour whom he saw when he was in the garden watering the plants. |
| 13.9 | The court was told that he had described everything as being normal on day he killed Jean and Sarah. He had said he had become distressed and that he just did it. He had said, *“I don’t know why, I don’t know why”*. He had added that he had no thoughts of violence even when he had strangled Jean. |
| 13.10 | He specifically denied planning to kill Jean and said that he had not harboured any homicidal thoughts leading up to the time he killed her. |
| 13.11 | The court heard that he had been concerned that Sarah would be distressed that her mother had been killed because they were very close. He decided to kill her and had put a hammer in the kitchen in preparation. He had waited for her to come home from work and had struck her 4 or 5 times with the hammer. |
| 13.12 | He said that what he had done did not make any sense to him. He also said that he had not been worried about the effect his own death would have on his family. |
| 13.13 | He had specifically denied experiencing psychotic symptoms at any point. He had though, lost his appetite, had nightmares, fear and negative feelings and had felt exhausted. |
| 13.14 | He had explained that he had decided to discontinue the medication altogether but had then agreed to go back on to a slightly different medication regime. The adverse symptoms eased but he still did not feel like eating, he felt tired and depressed and had problems sleeping. |
| **14** | **Case specific DHR issues** |
| 14.1 | * Whether the drugs prescribed to Peter Redfern after his diagnosis of multiple myeloma was a causative factor.   An internationally renowned Consultant haematologist and Professor of haematology was of the opinion that the care given to Peter Redfern was both excellent and appropriate. As mentioned previously, Peter Redfern was not taking any medication for a period of 6 days prior to 22nd July and in the opinion of the expert, it was very unlikely that the steroids he had been taking would have caused him to do what he did on that day. |
| 14.2 | Although Peter Redfern voluntarily took part in a drugs trial, it is important to note that the drugs themselves were not being trialled. The trial had been running for about four years, and had recruited over 2,200 patients across all age groups. The trial compares the outcome for patients treated with the standard initial therapy which is a combination of thalidomide, cyclophosphamide, and high dose dexamethasone (CTD) with the outcome for patients treated with a combination of Revlimid, cyclophosphamide and high dose dexamethasone (RCD). The trial is designed to test whether outcomes of treatment are better with RCD or with CTD. |
| 14.3 | * The information that was given to Peter Redfern and his family at the time of his prognosis and during his treatment   When the diagnosis of multiple myeloma was confirmed, he was told that his condition was treatable but not curable. He was given contact details of the haematology team and was told about the self-referral policy of the department (he actually made use of the self-referral policy when he suffered ill effects from the medication). He was also given a patient information pack including a booklet on myeloma, information on the drugs trial, a generic chemotherapy booklet, a key worker booklet, Macmillan cancer information, support leaflets and a Rotherham cancer centre booklet. |
| 14.4 | * The information sharing processes between Peter Redfern’s GP and The Rotherham Foundation Trust (TRFT) after Peter Redfern was diagnosed with myeloma.   Letters were sent by TRFT to the GP about the diagnosis and the agreed treatment pathway but little information was passed about what Peter Redfern and his family had been told of the prognosis and what support services were available to them. The GP has said that letters from the TRFT were delayed considerably which resulted in him not being able to form a judgment as to whether extra help could have been provided. |
| 14.5 | It was generally accepted by TRFT that there had been a delay in the GP receiving correspondence from the hospital and that the GP would have benefitted had TRFT outlined what counselling had been offered to Peter Redfern and whether the Macmillan service had been told about the diagnosis. |
| 14.6 | It was also accepted by TRFT that details of what leaflets and information that are given to patients could usefully be included in the patient notes. |
| **15** | **Comment on key DHR issues** |
| 15.1 | **Family engagement**  With the help of the police and the National Homicide Service, the RMBC Domestic Abuse Co-ordinator and the DHR Chair interviewed Mrs Stone and Mr and Mrs Randerson who were the closest relatives of Jean, Sarah and Peter Redfern. |
| 15.2 | The estranged cousins of Peter Redfern have not had any contact with him for 15 and 30 years respectively and were therefore not contacted during the review. |
| 15.3 | Friends and work colleagues were interviewed by the police and the Review Panel has been briefed as to what little they knew about the lifestyle of Jean, Sarah and Peter Redfern. The panel did not consider it necessary to seek to re-interview them. |
| 15.4 | Through his lawyers, Peter Redfern has been invited to contribute to this review, but to date he has not responded. |
| 15.5 | The panel decided that all media and communication matters would be handled by a joint team drawn from the South Yorkshire Police, the Rotherham Foundation Trust and the Safer Rotherham Partnership. It was agreed that the overriding aim was to protect the family from unwanted media attention so a reactive press statement was developed to cater for any enquiries that may have been made. Its purpose was to explain what a review was, why and who commissioned it and to stress that the review panel works closely with the family throughout the process. |
| 15.6 | An executive summary of the review will be published on the Safer Rotherham Partnership website, with an appropriate press statement available to respond to any enquiries. The recommendations of the review will be distributed via the partnership website and the partnership’s operational and strategic domestic abuse groups. They will also be shared with other agencies involved with responding to domestic abuse. |
| 15.7 | **Legal processes**  Many of the potential contributors to this review were likely to be witnesses in the murder trial. An early decision was made that the review would be suspended until the judicial process came to an end. When Peter Redfern was sentenced to 12 years imprisonment for manslaughter of Jean and life imprisonment for murder of Sarah, the review re-commenced. |
| 15.8 | There will not be an inquest into the deaths of Jean and Sarah because all the matters relevant to such proceedings were aired during the judicial process. |
| 15.9 | **Research**  Previous DHR’s have been scrutinised during this review to take account of lessons learned. |
| 15.10 | No conflicts or issues have been identified that would suggest that independent legal advice will be required about any aspect of this review. |
| 15.11 | **Diversity**  There were no issues around equality or diversity that require special consideration. |
| **16** | **Agency Individual Management Reviews (IMRs)** |
| 16.1 | IMRs are intended to review the respective organisations processes and their involvement and also to provide an analysis of the service they provided. |
| 16.2 | As mentioned previously, only the following agencies were required to provide an IMR:   * The General Practitioner * The Rotherham Foundation Trust |
| 16.3 | Both IMRs were quality assured by the respective agency, by the original author and Panel Chair. Where appropriate the IMR’s have been challenged and revised within agreed timescales. |
|  | **The IMR’s** |
| 16.4 | **General Practitioner**  The GP’s IMR described the chain of events between Peter Redfern attending the surgery in September 2012 complaining of back pain and his referral to the Orthopaedic Department at Rotherham District General Hospital. There was then a delay so the GP had to telephone the Consultant Orthopaedic Surgeon to expedite matters and eventually an MRI scan and a bone density scan were arranged. Subsequently, a bone marrow biopsy was conducted. The diagnosis of myeloma was confirmed on 11th June 2013 and chemotherapy commenced two days later. |
| 16.5 | The IMR then outlined the issues of TRFT letters about Peter Redfern’s treatment being delayed and the fact that there was no record of what counselling had been offered or whether the Macmillan service had been made aware of the diagnosis. |
| 16.6 | The IMR emphasised that there was no indication of any domestic abuse within the family and that they appeared to have been a well-adjusted family with no issues. |
| 16.7 | It went on to discuss that Peter Redfern had received a poor prognosis and that it appeared that counselling support may not have been put in place. |
| 16.8 | During the review process, TRFT accepted that there may have been some delays with the routine letters from them to the GPs practice, but did not accept the point about Peter Redfern receiving a poor prognosis; in fact they said his prognosis had been good. They added that counselling was offered as a matter of routine and that the offer had been declined. |
| 16.9 | **The Rotherham Foundation Trust**  The TRFT IMR described routine medical interventions undertaken by Jean and then described the treatment Peter Redfern received in respect of his myeloma, what he was told about his condition and prognosis (years rather than months) and details of some of the leaflets and information sheets he was given. There was an acknowledgement in the IMR that although Peter Redfern was provided with a wealth of written information regarding his condition and was also signposted to other support services, details of what literature he was given should have been documented. |
| 16.10 | The IMR made it clear that at no time were there any signs of domestic violence or abuse. On the occasion that Jean was with Peter Redfern when he attended the clinic, their interaction was described as being ‘normal’. |
| 16.11 | The independent author of the IMR concluded that the treatment and support offered to Peter Redfern had been appropriate and timely and that a particularly positive element of it had been the fact that he had often seen the same team within the haematology department. |
| 16.12 | From a TRFT internal learning perspective, the IMR identifies the difficult balance to be achieved between providing acute medical care to patients and being mindful of their emotional and mental health needs and social circumstances. The records gave a good picture of the medical care provided, but little was recorded about the emotional and mental health of Jean or Peter Redfern. |
| 16.13 | The IMR also identified an internal issue about there being no formal support mechanisms in place for staff throughout the course of a domestic homicide review, a child serious case review or subsequent criminal proceedings. |
| 16.14 | The IMR concluded that Peter Redfern’s treatment was of a high standard and that there was evidence of good practice throughout. Peter Redfern had been made aware on several occasions of the ‘self-referral’ policy and had demonstrated his ability to make use of it |
| 16.15 | Finally, it was the view of the author that the tragic events of 22nd July 2013 could not have been predicted. |
| **17** | **Multi agency responsibility** |
| 17.1 | **Multi Agency Risk Assessment Conferences (MARAC)**  Neither Jean nor Sarah was subject to MARAC.  (The MARAC process is well established within the region and there is a clear and unambiguous process surrounding it. Training and awareness has been provided and the process has been independently assessed and approved by CAADA (Co-ordinated Action Against Domestic Abuse), |
| 17.2 | **Multi Agency Public Protection Arrangements (MAPPA)**  Peter Redfern was not subject to MAPPA. |
| 17.3 | **Domestic Violence Perpetrator Programmes**  Peter Redfern was not involved in a Domestic Violence Perpetrator Programme. |
| 17.4 | **Contact with DV organisations/helplines**  Neither Jean nor Sarah had any contact with a domestic violence organisation or helpline. |
| 17.5 | **Vulnerable adults**  Neither Jean, Sarah nor Peter Redfern were ‘vulnerable adults’ within the definition of Law Commission Report of 1997. |
| 17.6 | **Communication and information sharing**  Appropriate information was shared between TRFT and the GP although on occasions it was slow to arrive. There is no evidence that this had any bearing on what happened to Jean and Sarah. |
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| **18** | **Individual agency responsibility** |
| 18.1 | Neither agencies’ policies nor procedures for safeguarding were invoked because neither Jean or Sarah nor Peter Redfern was known in a domestic abuse context beforehand. |
| 18.2 | There were no opportunities for assessment and decision making in relation to Jean or Sarah or to Peter Redfern and therefore management accountability for decision making was not tested in this instance. |
| **19** | **Conclusions** |
| 19.1 | None of the family, friends or work colleagues of Jean or Sarah or anyone within the Safer Rotherham Partnership agencies had any inkling that they would become victim of domestic violence or abuse. |
| 19.2 | Nothing could have been done to anticipate or prevent the tragic deaths of Jean and Sarah. |
| 19.3 | The medical care provided to Peter Redfern in respect of his diagnosis and treatment for multiple myeloma was of a high standard. He was provided with appropriate information and was made aware of and used the self-referral system when he encountered adverse side-effects of the prescribed medication. |
| 19.4 | Expert medical opinion was that Peter Redfern was suffering from depression as a result of the drugs he had been taking in the treatment of the myeloma. The trial Judge said that on the balance of probabilities he killed Jean on impulse when his mental functioning was abnormally affected. |
| 19.5 | The Judge said that Peter Redfern did not act on impulse when he murdered Sarah. He had made a deliberate and dreadful decision that he would kill her. He had planned it and had time to think about it. |
| 19.6 | The use of steroids can produce extreme mood swings in a small number of patients and can include confusion which is sometimes associated with aggressive behaviour. The effects rapidly resolve once the steroids are no longer taken but it is common for patients to feel low and depressed. Peter Redfern had ceased taking the medication 6 days before 22nd July, making it very unlikely that he will have been suffering from any side effects on that day. |
| **20** | **Recommendations** |
| 20.1 | The following recommendations are made: |
| 20.2 | The Rotherham Foundation Trust should ensure that supporting information given to patients is recorded in the case notes. |
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| 20.3 | The Rotherham Foundation Trust should review the provision of support it provides to staff following serious incidents. |
| 20.4 | There should be speedier communication between secondary and primary care following inpatient stays or outpatient appointments. Fax or email transmissions should be considered. |
| 20.5 | The Safer Rotherham Partnership is already aware that raising public awareness of domestic abuse is an on-going process. The partnership should be clear that Domestic Abuse is wider than physical violence and should include all types of abuse, including coercive control. It should also include the fact that abuse is age neutral and that it affects both men and women. |
| 20.6 | The existing Safer Rotherham Partnership public awareness domestic violence and abuse programme should be delivered regularly throughout the year and be made accessible to all. It should be examined to ensure it identifies all aspects of abuse and that it can deliver appropriate outcomes. |