

DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

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

Maeve

Written by Independent Chair, Anne Marks

FOREWARD – INDEPENDENT CHAIR

I would like to express, on behalf of the Domestic Homicide Review Panel, our deepest sympathy to Maeve's family, friends, and her community, on their loss.

'Maeve' is not her real name. To protect Maeve's privacy a pseudonym has been used to preserve her identity.

Maeve's adult son admitted killing his mother in her own home. At the time of Maeve's death, her son was temporarily living with her, providing care to Maeve following surgery. While Maeve was dependent on her son, the stresses of caring for her was no justification for her homicide.

During this Domestic Homicide Review, I have learned that Maeve was a proud mother. She took pleasure in her children's achievements and spoke of their accomplishments to others. Maeve was also a very private person. People who were close to her respected this.

I would like to put on record my thanks to Maeve's daughter for the contribution she has made to this report. She has helped enormously in understanding who Maeve was and in sharing what she knew of her lived experiences.

Domestic violence takes many forms. Maeve never articulated to anyone experiences of violence and abuse by her adult son, and there were no obvious indicators that he presented a risk to her. Yet he did go on to take her life.

Violence and abuse toward a parent by their family caregiver is an area less well known, or understood, in comparison to violence and abuse within intimate partner relationships. This Review has attempted to reflect Maeve's lived experiences and raise awareness of inter-family violence.

Anne Marks

FOREWORD – A PERSONAL NARRATIVE BY MAEVE'S DAUGHTER

Maeve was my mother. I don't want her to be pushed aside. I don't want her to be a number. My mother was a very private person. Through sharing some personal memories, I attempt to regain her dignity.

My Mum did well to raise the two of us on her own, my dad having left us when we were very young. She worked firstly as a bar maid but later became a housekeeper. Mum was very house-proud. Aside from that, she was brilliant at mental arithmetic, loved bingo, and in some respects was quite a cool person. She had friends in the golfing and financial banking circles yet, though, she retained her privacy. There were areas that she didn't want anyone to delve into.

In her later years, she would have felt lonely. She told me that in time I would understand what loneliness is, and I get it.

Mum liked plain simple food and one of my biggest regrets is that I didn't get to ask her for her recipe for home-made soup. I loved it. I remember a time I cooked a steak, medium to rare. When she spotted it resting, she ran out of the kitchen. It was too underdone for her.

Maeve was my Mum first before him. He didn't have the right to take her life. He didn't have the right to leave me without my mother, and my son without his grandmother. I have so many regrets having lost her so suddenly.

EXECUTIVE SUMMARY

This Domestic Homicide Review (DHR) deals with the circumstances surrounding the death of Maeve (pseudonym), an older person. Maeve's adult son Iain (pseudonym) killed his mother in her home. He later pled guilty to manslaughter by reason of diminished responsibility.

In the early hours of that morning, Iain messaged a friend indicating that he was going to harm himself and his mother. His friend contacted emergency services who made their way to Maeve's home. Maeve was discovered, deceased, in her bed. Iain told police that he had killed his mother and had then attempted suicide.

Iain, who lived outside the jurisdiction, was very close to his mother. He was Maeve's primary family caregiver and managed all of Maeve's needs from afar. Maeve was happy for him to be involved. Iain had temporarily moved in with his mother, to care for her following hip-replacement surgery. He had done similar three years before, when Maeve had undergone her first hip-replacement.

Unlike Maeve's first discharge home, following her first hip-replacement, on this occasion a domiciliary care package did not become available in her period of recovery. Maeve was firstly discharged to a residential Care Home to await a Package of Care, but several days later chose to return home without it, a decision supported by Iain. Both understood that Iain would have to assist with Maeve's personal care until a Package of Care would be available.

The month before Maeve's death, Iain informed the Health and Social Care Trust (HSCT) he was struggling to cope with his caring responsibilities, and his mental health was suffering. Furthermore, the week before her death, Iain contracted COVID-19 and was ill. He was very concerned that he would infect his mother. This created additional mental health issues for Iain.

From an organisational perspective, this Review considers how Maeve's caring needs were addressed post-surgery, and if this contributed to the risk Iain posed within the relationship.

From a societal perspective, this Review raises awareness of inter-family violence and, in doing so, seeks to identify opportunities for change and share good practice.

The Terms of Reference are as follows:

Purpose of the Review

- *Review the way in which local professionals and organisations that came into contact with Maeve, worked individually and together, to safeguard the victim.*
- *Review the way in which local professionals and organisations that came into contact with the alleged perpetrator, Iain, worked individually, and together, to tackle harmful behaviour and safeguard victims.*
- *Seek out opportunities for learning regarding the way in which local professionals and organisations work individually, and together, to safeguard victims and address offending behaviour.*
- *Consider whether there were any barriers to accessing services and how these could be addressed.*
- *Consider whether the victim was adversely impacted, in the context of COVID-19 restrictions, with regard to provision and access to services and resources.*
- *Identify clearly the lessons that are to be learned and the actions that are needed to change practice as a result, how and within what timescales this will be progressed, what is expected to change as a result (importantly this will include early learning that should be implemented ahead of a DHR formally concluding and being reported on and is considered key to the impact of the process) and how this will be measured. This relates to learning both within and between organisations and agencies.*
- *Apply identified lessons to service responses, including changes to policies and procedures as appropriate.*
- *Contribute to the prevention of domestic abuse and homicides and improve service responses for all domestic abuse perpetrators and victims through improved working (including strengthened partnership working) and ensure that domestic abuse (and associated abusive behaviour) is identified and responded to effectively at the earliest opportunity.*

- *Contribute to a better understanding of the nature of domestic abuse, and*
- *Highlight good practice.*

Specific issues to be addressed:

- *The individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, duty of candour etc.) to see whether the homicide indicates that any practice needs to be changed or improved, to support professionals to carry out their work to the highest standards and achieve the best outcome.*
- *How and when those changes or improvements will be brought about, and*
- *Examples of good practice within agencies.*

Overview of the Review Process

The Senior Oversight Forum, responsible for commissioning Domestic Homicide Reviews in Northern Ireland, determined Maeve's death met the criteria for a Domestic Homicide Review and appointed an Independent Chair.

The Independent Chair informed Maeve's daughter that a Domestic Homicide Review had been instigated. During the Review, contact was maintained with Maeve's daughter. The content of the final Review Report was shared with her prior to publication.

Iain was also advised, via his solicitor, that a Domestic Homicide Review had been commissioned.

The Independent Chair informed the HM Coroner's Office that a Domestic Homicide Review had been commissioned.

Criminal proceedings against Iain were taken account of as part of this Review. The Independent Chair maintained contact with police who were undertaking the homicide investigation.

A Domestic Homicide Review Panel was established, which consisted of a core group of senior managers representing key organisations, namely, the Police Service of Northern Ireland, the Probation Board of Northern Ireland, a Health & Social Care Trust, and the Strategic Planning and Performance Group. The DHR Panel also had representation from the voluntary sector, in this case Women's Aid. There were four Panel meetings.

The Panel analysed past events involving Maeve and Iain, collated from a range of sources, including witness testimony, and various organisational records, for example, medical records, social care case files, and the criminal investigation.

The DHR report was written by the DHR Chair, on behalf of the Panel.

KEY FINDINGS

KEY FINDING 1:

The demands of caregiving can be arduous. This exacerbated the perpetrator's pre-existing poor mental health.

Iain was the primary long-term family caregiver to his mother Maeve. Following surgery in 2019, and 2022, and at other times when Maeve was chronically unwell, Iain would stay with his mother assisting with her personal care, and other activities, such as cooking and shopping.

In between periods of illness, and despite living outside the jurisdiction, Iain continued to manage his mother's overall daily life. For example, he looked after the provision of Maeve's medication; he arranged and paid for a local woman to assist Maeve to shop and undertake errands; he helped with her online shopping; he spoke to professionals, as and when required, in terms of

Maeve's health or support she might need; and arranged modifications to her home that would aid Maeve in her daily life.

Following hip replacement surgery, Maeve went to a Care Home, awaiting a Package of Care that would allow her to return home. While waiting, Maeve chose to return home without a Package of Care in place. Iain supported this decision. Both understood that Iain would have to assist with Maeve's personal care until a Package of Care would become available. It was six weeks before the Package of Care became available, ten days before Maeve's death. However, at this stage, Maeve was assessed as no longer requiring this due to the level of progress she had made.

In the weeks leading up to Maeve's death, Iain informed the HSCT that he was struggling to cope, that his mental health was deteriorating, and, for the first time, had to avail of sickness absence from work. Iain was uncomfortable about availing of sick leave, and how it might impact on his colleagues. The HSCT enquired with Iain if he had thoughts of 'life not worth living.' He said he did not. The HSCT, however, encouraged him to contact his GP, provided telephone numbers for support services, offered him a carer's assessment, and a residential placement for Maeve, which he declined.

Maeve told visitors to her home that Iain was 'finding it all a bit much.' When the HSCT telephoned Maeve she said Iain's mental health had been impacted from looking after her. That same day Maeve's daughter had visited the home and noted the atmosphere to be very tense.

Iain had suffered poor mental health from his teenage years. Iain was also known to be physically ill, at times, in the weeks leading up to the homicide. There were periods when he had to rest in bed. Iain also contracted COVID the week before Maeve's death and was very concerned about infecting his mother. This created additional mental health issues for him.

In a letter written by the perpetrator, discovered on the day of Maeve's homicide, Iain had written that he was unable to take anymore, he had '*been broken since he was young,*' he had been looking after his mother over the previous number of weeks, it had been traumatic, and he could not leave her to endure the struggles alone. Examination of his mobile phone also indicated that he had searched the word 'matricide.'

Mental health symptoms, including anxiety, depression, insomnia, fatigue, a weakened immune system, can emerge from caregiving. Anger issues can develop because of accumulated stress, or resentment due to the caregiver's own unmet needs¹. For Iain, his period of caregiving exacerbated his pre-existing poor mental health and his fear he would pass on COVID-19 to his mother added to this.

Iain took the life of his mother using considerable force. He subsequently pled guilty to manslaughter by reason of diminished responsibility. This was accepted by the court.

KEY FINDING 2:

The COVID-19 pandemic created multiple stress factors within this relationship. This led to a worsening situation for the homicide victim who was relying on her son as caregiver.

An additional burden for Iain, as caregiver, and Maeve, as care receiver, was the unintended consequences of COVID-19.

Maeve was consistently anxious and fearful about her own physical health. She was extremely worried about contracting COVID-19. The fear of infection and fear of infecting was evident within the relationship. So, when Iain contracted COVID-19, shortly before Maeve's death, it is likely Maeve would have felt 'terrified'. This is likely to have been an added stressor in the relationship for both.

The effects of the virus on Iain's physical health meant he could no longer fulfil his caring responsibilities. He was ill and confined himself to his room, although by this stage the level of care Maeve required had reduced. The effects of the virus on Iain's mental health are also likely to have been further impacted by social isolation². Social isolation, when he was infected by COVID-19, compounded further as he was away from his home and support network (remaining COVID-19 restrictions had already been lifted by this stage).

¹ www.psychologytoday.com/gb/blog/insight-is-2020/202109/how-cope-the-stress-caring-aging-parents

² [Coronavirus and the social impacts on Great Britain - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/coronavirus)

Social isolation may also have been a factor in accelerating Maeve's desire to leave the Care Home, where she was recuperating post-surgery, to her own home without a Package of Care in place. It is known she was unhappy having at times to isolate from other residents for fear of the spread of COVID-19 infection.

The difficulty in obtaining a Package of Care was due to a regional shortage of domiciliary care staff and the impact of COVID-19 on service provision. Staffing levels were impacted by staff members contracting COVID-19 and this resulted in additional pressures on an already short-staffed domiciliary care sector. This led to Iain having an increased caring role, including assisting his mother with her personal care.

KEY FINDING 3:

The focus of the HSCT was on the needs of their client. While there was clear consideration of the carer's needs, in terms of their caring role, understanding the pressures within this home would have benefited from a whole family approach i.e., identifying and understanding the individual and combined needs of this family.

Iain was vulnerable due to poor mental health and physical illnesses, including COVID-19. He was also in an isolated position, away from his home, and the support of those he was close to.

Iain was caring for his mother post-surgery, a lady who was, and had been for many years, anxious and fearful about her own physical health. This may have compounded Iain's mental health and presented challenges in the care for his mother.

That said, there were no obvious indicators Iain presented a risk of harm. Maeve never disclosed any concern about their relationship, and she spoke of how well Iain had supported her in the past. There were no alerts recorded on the SOS CARE (Social Services Client Administration and Retrieval Environment) database system, or on the Northern Ireland Electronic Care Record. There were no previous referrals to Adult Protection, and no relevant reports held by police. If anything, Iain always presented as a caring and responsive son.

While Maeve, before her death, was recovering well and only needed assistance dressing below the knee, Iain's mental health, on the other hand, continued to decline, despite his caring role easing. Iain telephoned the HSCT's Community Care to share that his mental health had deteriorated. He was asked if he had thoughts of life not worth living, which he confirmed he did not. He was signposted to services of support, and advised that he had already been in contact with his GP. Iain, who sounded calm on the call, was offered a placement for his mother in a Care Home, until a Package of Care would become available, a Carer's Assessment, Family Career Training, and Carer's Grant, all of which was declined.

The following day, Occupational Therapy assessed Maeve and determined she had reached independence in her personal care. From this point onward Community Care understood the level of stress on Iain to be diminishing. This view was reinforced when Community Care telephoned Iain four days later who reported his mood had improved.

Four days after that, the HSCT's Community Care spoke to Maeve by telephone, and she disclosed Iain's mental health had been impacted from looking after her. Maeve was informed Iain had said his mental health had improved. Closure of the case to social work services was not formally discussed with her.

Later that day, Maeve's daughter came to visit her mother for the weekend. For part of the time, Iain was ill in bed. Maeve's daughter felt the atmosphere was very tense and Iain seemed under pressure.

The professional recognition and handling of Iain's disclosures, of the stresses he was under, would have benefited from in-person visits to consider the risks, stressors, and vulnerability factors, and to understand more of how well he was coping with his mother's physical and mental health difficulties. COVID-19, in the weeks leading up to Maeve's death, did not prevent direct visits by professionals. An in-person visit would have been useful when a carer's assessment was offered.

It is acknowledged Maeve had named only Iain in her care planning. However, understanding Iain's situation may have benefited from understanding the family as a whole, by involving Maeve's daughter, whom Iain was close to, and from further discussion with Maeve about Iain's

behaviours and her concerns. This may have helped identify and understand the individual and combined needs of the family, particularly in response to the history and changing circumstances of Iain's mental health. This may have helped them to negotiate their own solution to address their situation and individual needs.

CONCLUSION

Maeve's death has led to this Domestic Homicide Review.

Organisational processes were followed relating to Maeve's care and there were no obvious indicators to professionals that Iain presented a risk of harm. Systems and processes, the complex and interconnected environment within which professionals work, did not highlight any history of concern, and Maeve spoke positively about her son.

Nevertheless, a strengthening of systems focused practice has been identified in this Review. A separate Domestic Homicide Review, that concluded during the period of this Domestic Homicide Review, contains a Recommendation for this HSCT, elements of which has relevancy in this case. The Recommendation is as follows:

Develop an action plan and accountability structure in HSCT Community Care Division to practice within the Regional Think Family Strategy. The action plan will address:

- Improvement of a Mental Health Champions* model.
- Establish Domestic Abuse Champions*.
- A joint Training programme to support champions and their managers.
- Guidance on Co-working domestic abuse cases between programmes of care.
- Training on the impact of child to parent violence.
- Further guidance around thresholds for convening multi-disciplinary meetings across programmes of care.

- Guidance on an Escalation process around perpetrators of domestic violence and abuse.

* The term 'Champion' above is not only a title or designation. Rather it is a role that identifies opportunities for improvement, promotes and drives forward specific initiatives, and monitors and audits those initiatives to ensure the successful implementation.

It is the intention of the DHR Panel to raise public awareness that domestic violence and abuse takes many forms. As seen in this Review. Maeve was killed by her adult son, her primary caregiver.

It is also the DHR Panel's intention that the Key Findings, and the implementation of the identified action, will assist professionals in identifying the risks, stressors, and vulnerability factors, of domestic violence and abuse victims, and their perpetrators.

APPENDIX A

Agency	Recommendations
Rec. 1 HSCT	Develop an action plan and accountability structure in HSCT Community Care Division to practice within the Regional Think Family Strategy. The action plan will address: <ul style="list-style-type: none"> • Improvement of a Mental Health Champions* model. • Establish Domestic Abuse Champions*. • A joint Training programme to support champions and their managers. • Guidance on Co-working domestic abuse cases between programmes of care. • Training on the impact of child to parent violence. • Further guidance around thresholds for convening multi-disciplinary meetings across programmes of care. • Guidance on an Escalation process around perpetrators of domestic violence and abuse. <p>* The term 'Champion' above is not only a title or designation. Rather it is a role that identifies opportunities for improvement, promotes and drives forward specific initiatives, and monitors and audits those initiatives to ensure the successful implementation.</p>